

*REVIEW OF SERVICES FOR MENTALLY DISORDERED
OFFENDERS AND OTHERS REQUIRING SIMILAR
SERVICES*

*Official Working Group on Services for People
with Special Needs*

REFERENCE ONLY

THIS BOOK MAY NOT BE
TAKEN OUT OF THE LIBRARY

People with Learning Disabilities
(Mental Handicap)
or with Autism

Department of Health
Home Office
1992



The image on the cover of this report is reproduced from Bob Perske (1991) *Unequal Justice?*

Review of health and social services for mentally disordered offenders and others requiring similar services

PEOPLE WITH LEARNING DISABILITIES OR WITH AUTISM

1. The establishment of the Department of Health/Home Office review of health and social services for mentally disordered offenders and others requiring similar services was announced on 30 November 1990. A Steering Committee, under Dr John Reed, met for the first time on 31 January 1991. The review ended in July 1992. A *Final Summary Report* is being published, together with four other volumes which contain earlier consultative reports:

Volume 2: *Service needs* (the reports of the community, hospital and prison advisory groups and a Steering Committee *Overview*);

Volume 3: *Finance, staffing and training* (the reports of the staffing and training and finance advisory groups);

Volume 4: *The academic and research base* (the reports of the academic development and research advisory groups);

Volume 5: *Special issues and differing needs* (the report of the official working group on services for people with special needs).

2. This is a further report by the special needs working group. It considers services for people with learning disabilities (mental handicap/impairment) or with autism, focusing in particular on:

♦ *offenders (including the particular needs of the majority of offenders with learning disabilities who have "borderline" or mild to moderate disabilities);*

♦ *those (offenders or otherwise) who require secure provision;*

♦ *children and adolescents who fall (or appear vulnerable to falling) into the above categories, including their transition to adult services;*

♦ *offenders with autism.*

3. The report is being published for consultation. It was endorsed by the multi-disciplinary Steering Committee on 23 July 1992.

4. A discussion paper on *racial and cultural issues* (see paragraph 6.20), covering the range of services addressed during this review, is also being issued for consultation.

Mansell group

5. Another group, chaired by Professor Jim Mansell, has been looking at services for *people with learning disabilities and psychiatric or severe behavioural disturbance* (see paragraph 3.26 of this report). The Parliamentary Secretary for Community Care recently spoke about progress:

The report has now been submitted to the Department [of Health]. There is already a lot of information available about service models for people with learning disabilities and behaviour disturbance. This report focuses on the task facing commissioners of services - particularly appropriate as the purchaser/provider split extends from the health field to social services and identifies a number of factors relevant to success. It will be a useful document for all concerned with the needs of this client group. I am discussing arrangements for publishing, disseminating and for following it up (*Speech to MENCAP conference, 26 Oct 1992*).

security services

The Government has established a working group to look at high security psychiatric services (see paragraph 3.37), including those for people with learning disabilities. Its terms of reference, announced on 15 October 1992, will be:

To consider the most effective provision of services for patients requiring psychiatric treatment in conditions of high security in England and Wales, and the relationship between such services and the secure and related services provided within NHS Regions and the Prison Service, in the light of:

- the report of the Committee of Inquiry into complaints about Ashworth Hospital*;
- the results of the regional assessments of need submitted to the Department of Health;
- the conclusions of the review of services for mentally disordered offenders and the Special Hospitals Service Authority's strategic review;
- the results of the studies by Professor Gunn on the "treatment needs of prisoners with psychiatric disorders" and the "treatment and security needs of patients within Special Hospitals", and any other relevant data and research findings;

and to advise the Department of Health of the conclusions reached.

Department of Health guidance

7. On 26 October 1992 the Department of Health issued (as *Health Service Guidelines (92)42* and *Local Authority Circular (92)15*) revised guidance on learning disability services: see paragraphs 1.11-1.13 and Annexes V and W. Copies of the circulars are

available from DH Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancashire OL10 2PZ.

Special educational needs

8. The Audit Commission and Her Majesty's Inspectorate of Education have recently published a further report on special educational needs, *Getting the Act Together* (see also Hughes, *Proud to be one of the crowd, Independent*, 5 Nov 1992). This is a follow up to *Getting in on the Act*, the report of their study in 12 local education authorities: see paragraph 5.11.

9. The new Education Bill, published on 30 October 1992, addresses some of the issues. It would create an independent tribunal for parents' appeals, speed up identification of children with SEN and improve parental choice of schools for such children.

*London,
November 1992*

* *Report of the Committee of Inquiry into Complaints about Ashworth Hospital (Cm 2028)* (Chairman: Sir Louis Blom-Cooper), published on 5 August 1992.

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Acknowledgements

We are grateful to Dr Patricia Howlin of the Institute of Psychiatry for contributing the paper at Annex U on offending by people with autism. We thank also the following for permission to reproduce material:

- Figure 4: The National Autistic Society
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- Annex O: The University of Birmingham Centre for
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- Annex S: Professor Chris Kiernan (Hester Adrian Research Centre, Manchester)
- Annex T: West Berkshire Health Authority CHASAC team

Abbreviations

- AD REPORT OF THE ACADEMIC DEVELOPMENT ADVISORY GROUP
- CR REPORT OF THE COMMUNITY ADVISORY GROUP
- FN REPORT OF THE FINANCE ADVISORY GROUP
- HR REPORT OF THE HOSPITAL ADVISORY GROUP
- NR NEEDS AND RESPONSES (Department of Health, 1989)
- OV THE SERVICE ADVISORY GROUPS: AN OVERVIEW BY THE STEERING COMMITTEE
- PR REPORT OF THE PRISON ADVISORY GROUP
- RS REPORT OF THE RESEARCH ADVISORY GROUP
- SN REPORT OF THE OFFICIAL WORKING GROUP ON SERVICES FOR PEOPLE WITH SPECIAL NEEDS (June 1992)
- ST REPORT OF THE STAFFING AND TRAINING ADVISORY GROUP

KEY PRINCIPLES

Mentally disordered offenders who need care and treatment should receive it from the health and personal social services rather than in the criminal justice system. They should be cared for:

- ◆ *with regard to the quality of care and proper attention to the needs of individuals*
- ◆ *as far as possible, in the community, rather than in institutional settings*
- ◆ *under conditions of no greater security than is justified by the degree of danger they present to themselves or to others*
- ◆ *in such a way as to maximise rehabilitation and their chances of sustaining an independent life*
- ◆ *as near as possible to their own homes or families if they have them.*

These principles apply generally to offenders with learning disabilities and others requiring similar services.

Specific recommendations relating to people with learning disabilities

1. Suitable provision for people with learning disabilities, based on assessments of need, should be recognised explicitly as an aim of the medium secure programme (paragraph 2.22 of the special needs report).
2. The care programme arrangements should apply explicitly to offenders with learning disabilities leaving hospital or prison who need continuing care from the health and social services. The education services should, as necessary, be involved in such arrangements (paragraph 2.39 of the special needs report).
3. Staff in a range of agencies (particularly non-clinical staff) who come into contact with mentally disordered offenders should be trained to understand and, if possible, recognise the particular characteristics and needs of people with learning disabilities. They should also be able to distinguish between learning disabilities and mental illness (paragraph 2.8 of this report).
4. Definitive central guidance should be issued on the provision of services for offenders with learning disabilities and others requiring similar services. This should be brought to the attention of all relevant services, including criminal justice, education and housing agencies. It should take account of recommendations emerging from this review

and the parallel ("Mansell") group looking at services for people with learning disabilities and severe psychiatric or behavioural disturbance (*see paragraphs 3.26-3.28*), as well as requirements set out in earlier guidance (paragraph 3.1).

5. Local agencies should consider jointly practical ways of raising the service profile of offenders with learning disabilities (3.38).

6. Court diversion and assessment schemes should develop effective links with local learning disability teams and, where possible, team members should be encouraged to contribute to schemes, possibly on a rota basis (4.11).

7. Local agreements on the operation of section 136 of the Mental Health Act 1983 should give special consideration to the particular needs of people with learning disabilities (4.11).

8. At the very least, there should be a re-statement to health authorities that no Special Hospital patient requiring a transfer to a Regional or district facility should have to wait for more than a year. Transfers should normally be effected much more speedily than this. (*This should apply equally to mentally ill patients, who were covered by a similar requirement in Health Circular (88)43, and those with psychopathic disorder*) (4.19).

9. Agencies working with children with learning disabilities/difficulties should develop a coordinated range of specialised services, sensitive to the wishes of parents and children alike, to meet in the round the needs of those who develop behavioural difficulties (5.16).

10. Agencies should develop a joint approach to ensuring that adolescents with learning disabilities who offend or appear to be at risk of offending have access to a range of general and specialised services suitable for their age and stage of development and that they do not get drawn unnecessarily into the criminal justice system (5.22).

11. Local multi-agency groups for mentally disordered offender services and area committees for the criminal justice system should provide a clear focus for, or maintain effective links with, relevant services for people with learning disabilities (6.1).

12. Future needs assessments (carrying forward work done in the light of NHS Management Executive Letter (92)24 and undertaken on a multi-agency basis) should give more specific attention to the needs of people with learning disabilities (6.4).

13. Regional targets for medium secure beds should include a learning disability element specifically identified and related to a wider Regional strategy (6.9).

14. The Department of Health should issue practical guidance on the development of medium secure provision for people with learning disabilities (6.9).

15. Agencies should develop joint plans to identify and provide for the specific needs of people with mild to moderate learning disabilities, including in particular those who offend or are at risk of offending (6.13).

16. In planning services for, and delivering services to, offenders with learning disabilities, agencies should jointly take account of individuals' longer-term needs, including the social, clinical, educational and resource implications of failing to respond effectively (7.4).

17. Effective links should be maintained or developed between learning disability, general psychiatric, forensic psychiatric and child and adolescent psychiatric services. There may be scope for joint consultant appointments covering more than one of these specialties (7.15).

18. As part of the re-examination of training targets for nursing staff proposed at 11.180, health authorities should consider the particular requirement for skilled nurses to work with offenders with learning disabilities and others requiring similar services. They should address also the ways in which forensic psychiatric, general psychiatric and mental handicap nursing relate to each other (7.19).

19. The development of a core therapy service for mentally disordered offenders, as proposed at 11.163, should take account of the needs of offenders with learning disabilities and others with similar needs (7.29).

20. Having regard to the overall framework of research on services for mentally disordered offenders, priority for research on learning disabilities should be given to the areas identified at *paragraphs 8.2-8.3* of this report (8.5).

Autism (Chapter 9)

21. Agencies should take account of the specialised and varying needs of offenders with autism, including the importance of links with other services that may be required (9.12).

22. Agencies should train their staff to recognise and, where possible, respond to the special challenges that autistic people present (9.12).

23. There should be research into the range of responses required to meet the needs of autistic people who offend or who have severe behavioural problems (9.12).

Chapter 1:

Introduction

1.1. This is a report to the Steering Committee by the official working group on services for people with special needs. It concerns offenders with learning disabilities (mental handicap or mental impairment) or autism and others requiring similar services. The Committee endorsed the report at its meeting on 23 July 1992.

1.2. Our main report was submitted to the Steering Committee on 26 March 1992 and published for consultation on 2 June 1992, together with the reports of advisory group: on finance, staffing and training, research and academic development. Earlier advisory group reports dealing with services for mentally disordered offenders in the community, in hospital and in prison, together with an *Overview*, were published for consultation in November 1991.

Special needs report: June 1992

1.3. Our earlier report outlined some of the issues presented by people with learning disabilities. It made a number of recommendations for "special needs" services generally, as well as two specific recommendations for learning disability services: see paragraph 3.33 below.

This report

1.4. In announcing the publication of the earlier reports, the Parliamentary Secretary for Community Care indicated that further review work was being undertaken on the needs of people with learning disabilities (House of Commons *Official Report*, 2 June 1992, cols 453-4).

1.5. *This report focuses in particular on:*

i. offenders, including the particular needs of the majority of offenders with learning disabilities who are of borderline intelligence or have mild to moderate disabilities;

ii. those (offenders or otherwise) who require secure provision;

iii. children and adolescents who fall (or appear vulnerable to falling) into the above categories, including their transition to adult services;

iv. people with autism who come within the scope of the review.

1.6. *The report should be read in the context of the wider review findings and of general policy on services for people with learning disabilities.*

1.7. The membership of the working group is at *Annex A* and that of the Steering Committee at *Annex B*.

1.8. We are very grateful to all those who have assisted us with our work, including those we have met in the course of visits or who have attended other meetings with us. Through the consultation process, we have benefitted also from comments on the earlier review reports.

People with learning disabilities and severe psychiatric or behavioural disturbance

1.9. We have borne in mind the findings emerging from a Department of Health working group, under Professor Jim Mansell, that has been examining services for people with learning disabilities and severe psychiatric or behavioural disturbance (see paragraphs 3.26-3.28). We have not specifically addressed the needs of that group, except to the extent that they may bring someone into one of the categories identified above.

1.10. The Chairman and Department of Health Joint Secretary of the Steering Committee, together with our own chairman and secretary, met members of the Mansell group on 9 June 1992.

New guidance circulars on learning disability services (HSG(92)42 and LAC(92)15)

1.11. Shortly before this report was printed, the Department of Health published new circulars for health and local authorities on learning disability services: Health Service Guidelines (92)42 and Local Authority Circular (92)15. For ease of reference, these have been appended to the report as *Annexes V* and *W*. They supersede the 1991 draft circulars at Annexes D and E: see paragraph 3.13. The LAC includes an annex on *day care*. In a speech to coincide with publication, the Parliamentary Secretary for Community Care endorsed the "values and principles" for learning disability services enunciated in June 1991 by his predecessor (see paragraph 3.11) and described action by the Government to convert "rights into realities" (MENCAP conference, 26 Oct 1992): see *Annex X*.

1.12. Apart from adding this section, we have not sought to amend the text of the report which, in places, discusses the 1991 drafts. The content of the new circulars is very similar, though, on the health side in particular, taking account of wider developments in the purchase and provision of services.

1.13. An extract from the draft Health Circular at paragraph 3.14 about the needs of people who require "additional" health services has been re-cast as follows in the new HSG:

Purchasers should also consider contracting for services to meet the health needs of people with learning disabilities that cannot be met through contracts for the ordinary range of services...

Specialist mental health provision

Some people with learning disabilities need treatment for psychiatric illness or severe behavioural disturbance. If it is not possible to meet these patients' needs within the general psychiatric services, specialist assessment and treatment will be needed in hospital or community settings.

NHS residential care

The large majority of people with learning disabilities not living with their families can be cared for in residential accommodation arranged through the relevant social services authority. There are, however, likely to be a small number of people with severe or profound learning disabilities and physical, sensory or psychiatric conditions who need long term residential care in a health setting. Where this seems to be the case a multi-professional assessment and consultation with parents or carers are necessary to determine whether the services they need can only be provided by the NHS or whether other alternatives would be more appropriate and cost effective. Similarly, where such people are ordinarily cared for by their families, there may be a need for some short term respite care arrangements provided by the NHS (*HSG(92)42, Annex A*).



Chapter 2:

Terminology

*"Words are important: they shape the way
we think and influence the way we act."*

- *THE KING'S FUND, An Ordinary Life
in Practice (1988)*

2.1. This is a service area where terminology, moving in and out of vogue, arouses many sensitivities: see, eg, the *Sunday Times*, 3 May 1992; the *Independent*, Letters, 22 July 1992; Segal in *Observer Schools Report*, 18 Oct 1992; Brindle, *Guardian*, 28 Oct 1992. For the sake of clarity and consistency, we think it important to explain the sense in which we have used various terms. In the case of some research or other studies, we have referred to the diagnostic term used by the researcher or practitioner (even if this means apparent inconsistency with usage elsewhere in the report). Similarly, we have sought to amend extracts from earlier reports.

Learning disabilities/mental handicap

In a major policy statement to the annual conference of Royal MENCAP on 25 1991 (see paragraphs 3.11-3.13), the then Parliamentary Secretary for Health

Government policy in respect of whom? The name is important. It sends out signals; it has significant overtones and undertones. Without elevating the issue out of proportion, therefore, we have decided that the Department of Health will in future speak of "people with learning disabilities" rather than of "the mentally handicapped". The priority we attach to the provision of comprehensive health and social care services for people disabled in this way will of course be unchanged, but I hope that the change of terminology will reflect a change of emphasis in the philosophy of care and in the values which inform our thinking. Most importantly, it should reflect our commitment to linking of people with learning disabilities as individuals in their own right - people who are entitled to assistance in overcoming their disability for one simple reason - they are persons; they are full members of our society.

Accordingly, we refer in this report to *learning disabilities* where in the past we

would have said *mental handicap*. In *meaning* (if not emphasis) we have regarded these terms as synonymous, although we are aware, as a result of a number of comments made in the course of this review, that some practitioners and others are still a little wary of the "new" term (though perhaps less so than they were of "learning difficulties" in its "mental handicap" sense: see paragraph 2.14) and see it as insufficiently expressive of some of the profound disabilities which sometimes attend people within this client group. We recognise that meeting identified individual needs effectively and sensitively is ultimately a higher priority than verbal purity.

2.4. We have adopted the definition of "learning disabilities" in the glossary to the Steering Committee's *Overview* of October 1991:

This term...applies to people with a state of arrested or incomplete development of mind which includes significant disabilities of intelligence and social functioning.

Degrees of disability

2.5. Degrees of learning disability are generally described, for planning or broad descriptive purposes, as *mild*, *moderate* or *severe/profound*. These are not clinical terms. The Mental Health Act 1983 provides statutory definitions of *mental impairment* and *severe mental impairment* (see paragraphs 2.9-2.10). Reference to intelligence quotient is often unhelpful: "a division is of little practical significance to people either side of it" (*Better Services for the Mentally Handicapped* (Cmnd 4683), 1971).

Brain injury

2.6. Strictly speaking, we are concerned with people whose development of mind has been arrested because of circumstances present before, at, or during early childhood. Others whose intellectual development has been arrested or impaired by damage to the brain, for example, through abuse or accident, are described technically as *brain injured*. Services for offenders with brain injury were considered in our main report (SN 4.2-4.3). Some of these people may require access to learning disability services.

Mental illness

2.7. The term, *mentally ill*, is applied to people who *develop* "a disturbance of thought, mood, volition, perception, orientation or memory which impairs judgement or behaviour" (OV, Glossary). A person with learning disabilities may develop a mental illness as well.

2.8. Lay people are sometimes confused by the distinction between mental illness and learning disabilities. This may need to be addressed in the interests of effective identification and treatment of mentally disordered offenders.

The ideology of challenging behaviour

This model works well for many service providers concerned with people with learning difficulties. It helps to establish a positive approach to the role of services in meeting individual needs. For this reason, it is a deliberate aim of the Act to locate people with particularly serious or complex needs within the framework. One of the most obvious ways of achieving this is by the introduction and growing use of the term 'challenging behaviour'.

Terminology

Severely...
Words are important: they shape the way we think and influence the way we act.

THE KING'S FUND, An Ordinary Life...
in Practice (1988) ...safety of the person or others...
...jeopardy, or behaviour...
...access to and use of... Letters, 22
...erson et al 1989

The term 'challenging behaviour' is a new issue in a challenge to the Sunday Times, 18 Oct 1992. For the sake of clarity and consistency, we have referred to the diagnostic series of linked initiatives addressing key issues in the people with learning disabilities (mental handicap). The re-incorporated into a major statement on the Government development of services for people with learning disabilities

Subject to subsection (4) below, a child has a 'learning difficulty' if -
a. he has a significantly greater difficulty in learning than the majority of other children of his age; or
b. he has a disability which either prevents or hinders him from making use of facilities of a kind generally provided in schools, within the area of the child's residence, for children of his age; or
c. he is under the age of five years and is, or would be if special educational provision were made for him, likely to fall within paragraph (a) or (b) when over that age.

SECTION C: SERVICES FOR PEOPLE WITH DISABILITIES (MENTAL HANDICAP)

Policy Statement: During the early part of the year, a series of linked initiatives addressing key issues in the people with learning disabilities (mental handicap). The re-incorporated into a major statement on the Government development of services for people with learning disabilities

First point: Government policy

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"Then you should say what you mean", the March Hare went on.

I do", Alice hastily replied; "at least - at least I mean what I say - that's the same thing, you know."

Correct

2.3. Accordingly, we refer to...
be defined as "a state of arrested or incomplete development of mind that includes significant impairment of intelligence and social functioning" (2)
PART I
APPLICATION OF ACT

1.-(1) The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered persons, the management of their property and other related matters.

(2) In this Act -

"mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and "mentally disordered" shall be construed accordingly;

"severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly;

Importantly, it should reflect our

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Co-ordinated support is worth more than

sensitive labels, argues Stanley Segal

THE LABEL "MENTAL DISORDER" is the most commonly used term in the mental health field. It is a term that is used by doctors, nurses, social workers, and other professionals to describe a wide range of conditions, from mild anxiety to severe psychosis. However, the term is often used in a way that is stigmatizing and does not reflect the complexity of the conditions it describes. Stanley Segal, a leading expert on mental health, argues that the use of labels like "mental disorder" is a simplification of a complex reality. He believes that a more nuanced approach is needed, one that takes into account the individual's history, culture, and social context. Segal's argument is that the current system of labeling mental health conditions is flawed and that a new approach is needed to better understand and treat these conditions.

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sensitive labels, argues Stanley Segal

THE LABEL "MENTAL DISORDER" is the most commonly used term in the mental health field. It is a term that is used by doctors, nurses, social workers, and other professionals to describe a wide range of conditions, from mild anxiety to severe psychosis. However, the term is often used in a way that is stigmatizing and does not reflect the complexity of the conditions it describes. Stanley Segal, a leading expert on mental health, argues that the use of labels like "mental disorder" is a simplification of a complex reality. He believes that a more nuanced approach is needed, one that takes into account the individual's history, culture, and social context. Segal's argument is that the current system of labeling mental health conditions is flawed and that a new approach is needed to better understand and treat these conditions.

- * ***WE RECOMMEND that staff in a range of agencies (particularly non-clinical staff) who come into contact with mentally disordered offenders are trained to understand and, if possible, recognise the particular characteristics and needs of people with learning disabilities. They should also be able to distinguish between learning disabilities and mental illness.***

Statutory definitions

Mental impairment

- 2.9. *Mental impairment* is defined in the Mental Health Act 1983 as follows:

...a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned...(section 1(2)).

- 2.10. The Act defines *severe mental impairment* as:

...a state of arrested or incomplete development of mind which includes severe impairment of intelligence and is associated with abnormally aggressive or seriously irresponsible conduct...(ibid).

- 2.11. We use these terms to apply to the relatively small number of people with learning disabilities who may be diagnosed as *mentally disordered* within the terms of the Mental Health Act.

Learning difficulties

- 2.12. In line with recommendations in the Warnock report of 1978 (*Report of the Enquiry into the Education of Handicapped Children and Young People*, Cmnd 7212), the Education Act 1981 replaced special education for defined categories of mental handicap with a broader concept of provision to meet special educational needs (SEN). Under Section 1(2) of the Act, a child has a *learning difficulty* if:

- a. he [or she] has a significantly greater difficulty in learning than the majority of children of his age; or
- b. he has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided in schools, within the area of the local authority concerned, for children of his age; or
- c. he is under the age of five years and is, or would be if special educational provision were not made for him, likely to fall within (a) or (b) above when over that age.

- 2.13. Section 1(4) of the Act provides that a child is not to be taken as having a learning

difficulty solely because the language (or form of language) which he or she is, or will be, taught is different from a language (or form of language) which has at any time been spoken in his home.

2.14. During the 1980s "learning difficulties" gained wide currency as a synonym for "mental handicap". However, in this report, we use the term only as defined for statutory purposes (ie we do *not* do so as an alternative to "learning disabilities").

Behavioural difficulties/challenging behaviour

2.15. *Behavioural difficulties (disorders/disturbance)* are those of irresponsible, assaultive or destructive behaviour which challenge the health and social services: hence, the term, *challenging behaviour*, used by many. Such behaviour may include bouts of aggression, (for example, hitting, biting, scratching, hair-pulling or throwing missiles) and sometimes serious assault (NR 4.1). Socially unacceptable behaviour includes incontinence, faecal smearing, undressing and uninhibited sexual behaviour. Among other behavioural features are general restlessness, noise, hyperactivity and self-injury. Frequency and predictability may vary considerably.

2.16. The main difficulties posed by people with *autism* arise from impaired social interaction and behaviour. Autistic behaviours (see Chapter 9) include repetitive movements such as touching, finger-flicking and spinning.

2.17. A definition of *severely challenging behaviour* used by the Mansell group is at paragraph 3.27.

Chapter 3:

The policy inheritance

3.1. We have found it a helpful preliminary exercise to trace the development of policy in this service area and to identify relevant requirements. There is widely thought to be something of a policy vacuum. In fact, this is rather less true than some have suggested: see particularly paragraph 3.16 which emphasises definitively the need for a range of specialised and other services. But undoubtedly more needs to be done to clarify what is expected of the various agencies. Attention must also be given, of course, to the relevance of existing guidance to current needs.

- * *WE RECOMMEND the issue of definitive central guidance on the provision of services for offenders with learning disabilities and others requiring similar services. This should be brought to the attention of all relevant services, including criminal justice, education and housing agencies. It should take account of recommendations emerging from this review and from the parallel group looking at services for people with learning disabilities and severe psychiatric or behavioural disturbance (see paragraphs 3.26-3.28), as well as requirements set out in earlier guidance.*

THE DEVELOPMENT OF GENERAL POLICY ON LEARNING DISABILITIES

1954-7 Royal Commission

3.2. As long ago as 1957 the Percy report (*Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, op cit*) recommend a new emphasis on community care and the breaking down of segregation between mentally handicapped people and the general population.

1971 White Paper

3.3. The elements that constitute a modern learning disability service were described in the 1971 White Paper, *Better Services for the Mentally Handicapped* (Cmnd 4683). Subsequent developments have reflected a marked trend away from institutional care and have re-emphasised the rights and dignity of people with learning disabilities, including the scope for bringing them into mainstream health, social services and educational provision.

3.4. Between 1969 and 1977 the number of people over 16 in NHS mental handicap hospitals or units fell by about 600 annually from 49,000 to 44,000, compared to a slight increase between 1963 and 1969 (DHSS (1981) *Mental Handicap: Progress, Problems and Priorities*, paragraph 2.28). By 1991 the number of in-patients with learning disabilities had fallen much more sharply to 22,100, well within the 1971 White Paper target of 27,300.

3.5. During the past twenty years, community provision, in particular that in the local authority and voluntary sectors, has grown steadily. We look at current service levels in more detail in Chapter 4.

Recent policy guidance on general learning disability services

1988 planning guidelines: HC(88)43/LAC(88)14

3.6. Planning guidelines issued with Department of Health Circular (88)43/Local Authority Circular (88)14 identified a number of policy aims for general learning disability services:

- i. to develop at local level...a comprehensive and integrated range of health, social and other services for mentally handicapped people and their families, with provision for assessing and prioritising individuals' particular needs for these services;
- ii. to provide:
 - a. specialist and generic health care for people with special medical or nursing needs, including small residential units in the community and specialist support for people in other settings;
 - b. good quality care for mentally handicapped people in all settings, including maintaining and, where necessary, improving standards in large hospitals as their populations reduce;
 - c. as a consequence of these developments to reduce dependence on the larger hospitals for mentally handicapped people. The closure of hospitals is not a primary aim;
 - d. Regional Health Authorities should ensure that no patient who was or is

mentally impaired or severely mentally impaired, who is awaiting a move from a special hospital to a Regional or district facility, waits for more than one year [SN 2.18 and paragraph 4.19 below].

3.7. As noted in the 1988 circular, Government policy was described in greater detail in Annex 2 to the Government's *Response to the Second Report from the Social Services Committee, 1984-85 session* (Cmnd 9674, 1985): see paragraph 3.16 below. Department for Education circulars on the operation of the Education Act 1981 and relevant subsequent legislation are an important adjunct to health and social services guidance (see paragraph 5.8).

People with other special needs

3.8. The needs of people with learning disabilities who have other disabilities or difficulties were addressed in the report of a DHSS study team, *Helping Mentally Handicapped People with Special Problems* (1984). This looked at residential and day services for people with additional sensory impairments, day services for those with profound disabilities and the needs of elderly people. Consideration was given also to people with behavioural disturbance (see paragraph 3.19), although recognition that further thought needed to be given to this and related areas gave rise to a separate study, the outcome of which was the 1989 discussion document, *Needs and Responses* (see paragraphs 3.21-3.23).

3.9. We ourselves addressed some of the issues of sensory deprivation in our earlier report (SN, *Discussion Paper 2*).

3.10. The 1988 guidelines (see paragraph 3.6 above) required every district health authority to have a policy statement for meeting the needs of people with learning disabilities for which the NHS has "the relevant skills, expertise and responsibility". These were to include:

- i. services for people who have a mental handicap and other special needs (eg because they are also physically, sensorily or multiply handicapped)....
- ii. the provision of mental handicap nursing, clinical psychology, occupational therapy, physiotherapy, speech therapy and incontinence and disability equipment services.

1991 policy statement and draft circulars

Values and principles

3.11. In his statement of June 1991 (see paragraph 2.2 above and *Annex C*), the then Parliamentary Secretary for Health, Mr Stephen Dorrell, identified what he described as a set of "right values and service principles":

first, that people with a learning disability - of whatever degree - are entitled to be

first, that people with a learning disability - of whatever degree - are entitled to be treated with the same respect and dignity as everyone else...

second..., that people with a learning disability should have their health and social care needs assessed on an *individual* basis, and not be offered pre-determined sets of services...

third, that people with learning disabilities have the same rights in relation to statutory services as anyone else. This includes the right to both primary, and secondary health care as well as the right to have their needs for social care assessed. To secure this in reality means that any special difficulties they may have in enjoying equality of access and assessment must also be recognised and assessed.

The key role of social services

3.12. Mr Dorrell highlighted also, with reference to the *National Health Service and Community Care Act 1990*, the growing emphasis on social care and the role of social services:

During the last twenty years local authority social service departments have increasingly been seen as the main statutory agency for planning and arranging services, not only to people with a mild or moderate learning disability, but also to those with a severe or profound disability. The Government welcomes this development. As the changes resulting from the NHS and Community Care Act come into force, local authorities will have the clear statutory responsibility for assessing and as far as practicable meeting the social care needs of people with a learning disability...

Local authorities will need to plan and arrange a wide range of home based, day and residential services, often by contracting them from the voluntary and private sectors. Even more importantly they will have to do so in ways that give people with learning disabilities and their families confidence in the continuity of support...

3.13. In conjunction with the policy statement, the Department of Health issued draft circulars for health and local authorities (see *Annexes D and E*). We understand that, subject to some revisions, these are likely to be formalised shortly. They too emphasise the central contribution of social services, including the need to give

"particular priority to provision for people with learning disabilities and special needs"; and

"to take account of age, needs, degree of disability, personal preferences..., culture, race and gender".

They stressed also the importance of identifying health and housing needs and of close working with local education authorities.

The continuing role of the NHS

3.14. In our earlier report (SN 1.10), we noted in particular (as have others we have met in the course of this review) the draft Health Circular reference to the need for health

authorities to consider contracting for "additional services", including:

specialist assessment and treatment services, in hospital or community settings, where patients with learning disabilities need treatment for psychiatric illness or severe behaviour disturbance that cannot be met adequately within the general psychiatric services; and residential care (or respite care) for people with severe or profound learning disabilities and physical, sensory or psychiatric conditions, where a multi-professional assessment and consultation with parents and carers leads to the conclusion that only the NHS can provide the services they need cost effectively. *See now paragraphs 1.11-1.13 above.*

3.15. More recently, the present Parliamentary Secretary for Community Care, has reaffirmed the role of the NHS "in meeting the long and short term needs of people with learning disabilities" and the importance of inter-agency planning:

In the transition to community-based services health authorities have a continuing responsibility for residents of mental handicap hospitals and others for whom they have been providing social care. Changes in the current pattern of provision of services should only be made as part of an agreed strategy between the relevant health and local authorities (*House of Commons written answer, 12 May 1992*).

PEOPLE WHO ARE A RISK TO THEMSELVES OR TO OTHERS, WHO OFFEND OR ARE "DIFFICULT TO PLACE"

3.16. The hospital advisory group of this review noted (HR 5.7) that Government policy already requires Regional Health Authorities (RHAs) to ensure that adequate capacity is planned and developed for people with a mental illness or learning disabilities "who are violent or are offenders, or are, for various reasons, difficult to place":

Each Region needs to develop a strategy so that it can offer a comprehensive range of services...so that NHS deficiencies in accommodation or in the necessary skills to manage them do not mean that people who ought to be in-patients in NHS hospitals remain in prison, in special hospitals, or in the community. Regional secure units and interim secure units are important elements in this range, but other elements are needed also. For example, the Region should know where care can be given to mentally handicapped people who need medium security with a suitable environment (and) to mentally handicapped people with mental illness (*Response to the Social Services Committee (1985)*), *op cit*, Annex 1).

Butler/Glancy (1974-5)

3.17. Following the reports of Butler (*Report of the Committee on Mentally Abnormal Offenders* (Cmnd 6244), 1975) and Glancy (DHSS (1974) *Report of the Working Party on Security in NHS Psychiatric Hospitals*), the then Department of Health and Social Security issued guidance to health authorities on "services for those mentally ill and mentally handicapped people who, although not having the dangerous or violent

propensities which would require their admission into a Special Hospital, cannot be managed in the ordinary wards of psychiatric hospitals" (HSC (IS)61): see *Annex F*. This is extant.

3.18. An initial overall target of 1,000 medium secure beds in Regional Secure Units (RSUs) was set, based on the figure proposed by Glancy. Butler had recommended 2,000 beds. Glancy considered that secure units were unsuitable for patients with severe learning disabilities and that suitable facilities should be developed in ordinary mental handicap hospitals (*op cit*, paragraph 37(2)). Central funding was made available to develop the RSU programme. At 31 January 1992, none of 602 staffed and available permanent RSU places was for people with learning disabilities, although 14 such beds in Oxford Region had recently been closed and there was a number of other NHS beds for this group in varying degrees of security (see paragraph 4.16). As we observed in our earlier report (SN 2.20-2.21):

For the future, the medium secure programme needs to be more broadly based. Apart from adult mental illness, the major area for potential expansion is in services for people with learning disabilities. Since there has been much uncertainty about the point, it has recently been made clear to RHAs, through invitations to bid for central funding in 1992/3, that the programme includes this group. The increase of available capital from £3 million in 1991/2 to £18 million in 1992/3 should begin to provide greater scope for diversity.

DHSS study group report (1984)

3.19. *Helping Mentally Handicapped People with Special Problems (op cit)* identified the following key points for those managing and planning services for people with behavioural problems:

- i. those planning services at Regional level may wish to consider whether a small multi-disciplinary unit, staff from which can act as a resource base and can facilitate referrals for assessment and treatment, should be established;
- ii. staff ratios should be high enough to maintain consistent treatment and such treatment should best be provided in small homely units;
- iii. day care facilities for this group can successfully be provided by local authority special care units with support from NHS professional staff;
- iv. staff for specialist units for behaviourally disturbed clients should be carefully selected and should receive appropriate training. They will need good management support and counselling;
- v. a resource team of training staff with good behaviour modification skills who can advise other members of staff throughout a hospital district or local authority area can be extremely helpful (*ibid*, Chapter 15).

3.20. As noted at paragraph 3.8 above, this report left further work to be done. In particular it saw the difficulties posed by people with a dual diagnosis of learning disabilities and mental illness, people with mild learning disabilities and those with autism as being outside its remit.

Needs and Responses (1989)

3.21. The Department of Health study team report, *Needs and Responses: Services for Adults with Mental Handicap Who Are Mentally Ill, Who Have Behaviour Problems or Who Offend* (1989), looked in particular at people with learning disabilities who are mentally ill and whose behaviour causes difficulties in management, those who are behaviourally disturbed, and offenders. It looked briefly at autism (NR 4.15-4.16). Its findings, which are summarised at *Annex G*, were designed, as Mr Dorrell put it in his 1991 statement, "to stimulate local thinking about a set of issues for which there is plainly no simple or agreed service response".

3.22. Of *offending*, which is uncommon among people with learning disabilities (see paragraph 4.2 below), the report drew attention to two key areas since identified in the present review: access to additional specialised services to meet assessed need (NR 5.18-5.19) and a range of health, social service and criminal justice agencies working closely together (NR 5.21). It emphasised also the importance of prevention (see paragraph 6.8 below) and saw secure provision as a "major issue to consider":

All levels of security, less than that provided by Special Hospital, need to be available. Inappropriate applications for admission to Special Hospital result from a failure to provide the appropriate facilities locally (NR 7.25).

3.23. It continued:

There must be access to special in-patient units, which are likely to be sub-Regional or Regional, for evaluation and treatment, both short-term and long-term. Whatever placement is found, there must be adequate, continuous, planned after-care facilities, including long-term care for those who need it (NR 7.26).

BIMH seminars (1990)

3.24. In 1990 the British Institute of Mental Handicap, with the support of the Department of Health, mounted two regional seminars (in Manchester and Bristol) and a national conference to examine progress in introducing services for people with "learning difficulties [*sic*] who also present challenging behaviour": see BIMH (1991) *Service Responses to People with Learning Difficulties and Challenging Behaviour: Seminar Papers No 1* (Department of Health Local Authority Social Services Letter (91)8). These revealed a widely-held view that policy and services were failing to match need and that a more positive agenda was required for the coming decade. One speaker, for example, felt that "the ideas of the 1980s now seem to be largely irrelevant in the world of purchasers and providers, of trusts and traders, of case managers and service brokers" (BIMH, *op cit*).

3.25. The BIMH report identified a number of issues which were thought to require urgent attention. These included a perceived lack of clarity in national and local policies; problems of defining the client group and the effect of this on service development; the role of community services in meeting specialised needs; the

assessment of resource implications; staff recruitment, retention and training; and the dissemination of examples of good practice. Viewed more generally, most of these issues have been key factors in the current review.

Mansell (1991-2)

3.26. In the course of his 1991 policy statement, Mr Dorrell announced the establishment of a small group to look at the needs of people with learning disabilities and psychiatric or severe behavioural disturbance:

This group's task is to identify the necessary elements of a successful service and produce much more specific guidance than is currently available. They will also keep in touch with the parallel review of services for mentally disordered offenders.

3.27. The group was chaired initially by the late Peter Searle and latterly by Professor Jim Mansell. It adopted the following working definition of its client group (Emerson *et al*, 1987):

Severely challenging behaviour refers to behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities.

3.28. We have followed the work of the Mansell group and its secretary is a member of our own group. Its report has recently been submitted to the Department of Health.

Home Office Circular 66/90 and the present review (1990-2)

3.29. When he announced the establishment of the present review in November 1990, Mr Dorrell said that "we need to find better ways of providing for those offenders with... mental handicap who are not regarded by clinicians as treatable within the terms of the [Mental Health] Act" (Department of Health Press Release H90/581).

General framework and principles

3.30. The general framework established by the earlier service advisory groups (see *Overview* extract at *Annex H*), and by Home Office Circular 66/90 on the diversion of mentally disordered offenders (CR, Annex B; NHS Management Executive Letter (90)168: see *Annex I*), apply generally to offenders with learning disabilities. So also do the five guiding principles of the review (OV 16), endorsed by Ministers (House of Commons *Official Report*, 13 November 1991, cols 583-4), which are that patients should be cared for:

- ♦ *with regard to the quality of care and proper attention to the needs of individuals;*
- ♦ *as far as possible, in the community, rather than in institutional settings;*
- ♦ *under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;*
- ♦ *in such a way as to maximise rehabilitation and their chances of sustaining an independent life;*
- ♦ *as near as possible to their own homes or families, if they have them.*

Special needs report (June 1992)

3.31. The earlier report of our own group identified some further basic requirements for "special needs" services (which, for the purpose of the review, includes those for people with learning disabilities) (SN 2.2):

- i. that agencies adopt a positive and non-prejudicial approach, at both planning and operational level, to identifying and meeting special needs;
- ii. that effective links are maintained between specialised forensic, criminal justice and other relevant services (learning disability, drugs and alcohol, etc);
- iii. that service provision is tailored to individual needs; and consequently:
- iv. that, in individual cases, the balance struck between the contribution of the various services is in the best interests of the patient.

3.32. It is important also (SN 2.5) that:

- i. patients are not disadvantaged through assessment or service provision that is based on unjustified assumptions or "stereotyping"; and that
- ii. needs common to all people are not overlooked (for example, "life stresses", such as puberty, sexuality and ageing, are as significant for a person with learning disabilities as they are for the general population).

3.33. We made two specific recommendations for learning disability services, although several general recommendations, including for the health care of prisoners, are also relevant: see *Annex J*. The specific recommendations were:

- i. that suitable provision for people with learning disabilities, based on Regional assessments of need, is explicitly recognised as an aim of the medium secure programme (SN 2.22 and paragraph 3.18 above);*
- ii. that the care programme arrangements [CR 3.14-3.18; ST 5.30-5.35; Department of Health Circular (80)23] should apply explicitly to offenders with learning disabilities leaving hospital or prison who need continuing care from the*

health and social services. The education services should, as necessary, be involved in such arrangements (SN 2.39 and paragraph 6.18 below).

Maintaining services and assessing need

3.34. The implementation of two other review recommendations has had implications for learning disability services:

i. *NHS Management Executive Letter (92)6* of February 1992 (SN, Annex G) requires Regional General Managers to maintain existing services for mentally disordered offenders and patients with similar needs at least until 31 March 1993. This includes "services for patients with "special needs" such as mentally disordered adolescents and those with learning disabilities and personality disorders";

ii. *needs assessment*. As part of the review, Regional Directors of Public Health, in conjunction with other agencies, were required to conduct a needs assessment (Executive Letter (92)24). This was to include relevant learning disability services (see paragraph 6.3 below).

The Health of the Nation (1992)

3.35. The White Paper, *The Health of the Nation* (Cm 1986, 1992) contains the following statement:

The essential task...is to ensure that mentally disordered offenders who need specialist health and social care are diverted from the criminal justice system as early as possible. Authorities' strategic and purchasing plans should include the necessary range of health and social services (both secure and non-secure) to enable them to respond to these people's special needs.

Other recent initiatives

SHSA/MENCAP conference on severe learning disabilities (March 1992)

3.36. A conference at Rampton Hospital in March 1992, organised jointly by the Special Hospitals Service Authority and MENCAP, addressed a range of issues, including Special Hospital provision, the voluntary sector perspective, the resettlement of people with severe learning disabilities and possible future models of care for such people. A report is being prepared.

High security services and their relationship with other services

3.37. In her statement (5 August 1992) on the *Report of the Committee of Inquiry into Complaints about Ashworth Hospital* (Cm 2028), the Secretary of State for Health announced the formation of a working group "to consider the most effective provision of services for patients requiring psychiatric treatment in conditions of high security, and the relationship between such services and those provided within NHS regions and the Prison Service" (Department of Health Press Release H92/251).

Manchester conference: "Unequal Justice?" (May 1992)

3.38. A recent attempt to examine the local interface between learning disability services and the criminal justice system was mounted by the Tameside Association for Community Living, in conjunction with the Greater Manchester Police. A one-day multi-agency conference in May 1992 addressed a number of the key issues facing those who come into contact with offenders with learning disabilities: see summary report at *Annex K*. A follow-up conference is planned for next year. Similar conferences or workshops may be a useful means of projecting the needs of offenders with learning disabilities.

- * *WE RECOMMEND that local agencies consider jointly practical ways of raising the service profile of offenders with learning disabilities.*

Chapter 4:

Current service levels

4.1. As with many other areas of this review, it is difficult to isolate data on services for offenders with learning disabilities. This is only to be expected, given that many of the client group will receive the same sort of mainstream services as non-offenders, but the present paucity of information does create planning difficulties, including problems of estimating resource requirements. The progressive refinement of *needs assessments* (see paragraphs 6.2-6.4) and more effective (preferably multi-agency) *information systems*, with suitable safeguards, as recommended by the staffing and training advisory group, should assist greatly in the future (ST 5.16-5.21).

4.2. Various studies suggest that the rate of offending among people with learning disabilities is very low, probably accounting for no more than 1% of the learning disabled population (NR 5.1). Prevalence of offending or of behavioural disorders (the latter perhaps 20 per 100,000 of the general population: NR 4.2) can, in some cases, help to provide crude pointers to existing service inputs, but, looking to the future, it must be borne in mind that many offenders are wrongly located in the system and that the use of "norms" is no substitute for proper needs assessment (ST 1.9-1.10).

Unmet need

4.3. What is clear - and this has been highlighted by, among others, the Mental Health Act Commission (see, *eg*, its *Fourth Biennial Report 1989-1991*, paragraphs 10.1-10.4) - is that suitable specialised provision is patchy and that the service profile of this group has been very low, probably lower than that of mentally disordered offenders generally. One reason is that many offenders have mild to moderate learning disabilities (NR 5.1.). They do not come within the scope of the Mental Health Act and their needs frequently go unidentified or unmet until (as one commentator put it to us) "they progress further up the tariff system". This may be especially so of offenders, albeit a relatively small number, who end up in prison (see Gunn *et al* (1991) *Mentally disordered prisoners* and paragraphs 4.22-4.26 below). Another factor is that the (perfectly proper) emphasis on social care in the community for the vast majority of people with learning disabilities has led to various specialised requirements (for example for secure health care) escaping the interest of some purchasers and providers. Indeed, the view was put to the hospital advisory group that one effect of contemporary service patterns was to expose more of

the learning disabled population to the risk of offending, with consequent service implications (Day, 1991). The 1991 draft circulars (see Annexes D and E) should help to reinforce purchaser obligations.

Community services

Residential and day care

4.4. In 1991 there were 3,400 *residential homes* in England for people with learning disabilities providing 35,600 places (more than double the figure in 1979). Local authorities provided 47% of places, over 80% of which were in staffed homes. Voluntary and private homes provided about a half each of the remainder (although, in the past decade, a six-fold expansion in the private sector has relatively far out-stripped that in the other sectors). Nationally there were 117 residential places per 100,000 population aged 16-64: see *figure 1*.

4.5. *Adult training centres (ATCs)* and *social education centres* provide a range of day services for people with learning disabilities. They cover areas of personal, social and vocational competence and aim to develop people to their highest level of potential. *Special needs (special care) units (SNUs)*, sometimes attached to ATCs, provide for people who, in addition to severe learning disabilities, have additional difficulties such as a profound physical handicap or behavioural disturbance. At March 1991 there were 662 local authority *ATCs and SNUs* with 56,723 places (an increase of 35% over 1979). The rate of places per 1,000 population aged 16-64 was 1.8: see *figure 2*. *Resource centres* can also play an important part, providing a range of day services, including for those who are unemployed and, in some areas (especially at present major provincial cities), people from ethnic minorities (see paragraphs 6.19-6.20).

4.6. A survey of ATC and SNU clients in 13 local authority areas indicated that 28% in ATCs and 48% in SNUs displayed aggressive or destructive behaviour which presented some management problems, while 5% in ATCs and 37% in SNUs inflicted injury on themselves. 7% of ATC and 6% of SNU clients posed problems of delinquency (Social Services Inspectorate (1989) *Individuals, Programmes and Plans*, Tables 1 and 2).

Points of contact

Court diversion schemes

4.7. By June 1992 there were over 40 court diversion schemes (CR 2.28-2.32; ST 5.22-5.30) in operation in England, with over 30 more known to be planned or starting shortly (Blumenthal and Wessely (1992) *The Extent of Local Arrangements for the Diversion of the Mentally Abnormal Offender from Custody*).

Figure 1

Residential places for people with learning disabilities at 31 March 1991

Region	Local authority		Registered		All Homes
	Staffed	Unstaffed	Voluntary	Private	
Northern	1,103	176	238	350	1,867
Yorks/Humberside	1,712	392	742	813	3,659
North Western	2,154	471	897	730	4,252
West Midlands	1,746	229	1,010	911	3,896
East Midlands	879	373	642	1,034	2,928
Thames/Anglia	2,024	601	1,615	1,354	5,594
Inner London	539	68	601	38	1,246
Outer London	1,183	146	618	276	2,223
Southern	1,232	243	1,669	2,376	5,520
South Western	1,188	219	1,474	1,500	4,381
England	13,760	2,918	9,506	9,382	35,566

Rates per 100,000 population aged 16-64

Region	Places in residential homes				
	Local authority		Registered		All Homes
	Staffed	Unstaffed	Voluntary	Private	
Northern	56	9	12	18	95
Yorks/Humberside	54	12	23	26	115
North Western	53	12	22	18	105
West Midlands	52	7	30	27	116
East Midlands	34	14	25	40	113
Thames/Anglia	44	13	35	30	122
Inner London	35	4	39	2	80
Outer London	41	5	21	10	77
Southern	35	7	47	67	156
South Western	41	7	50	51	149
England	45	10	31	31	117

Figure 2

Adult Training Centres and Special Needs Units for people with learning disabilities, at 31 March 1991

Region	Special Needs Units				Adult Training Centres and Special Needs Units		
	Attached to ATCs		Separate units		Number of centres/ units	Number of places	Rate per 1,000 population 16-64
	Number of units	Number of places	Number of units	Number of places			
REGIONAL TOTALS							
Northern	20	272	4	58	55	4,251	2.1
Yorks & Humberside	24	448	5	80	72	5,895	1.9
North Western	59	992	11	231	101	8,498	2.1
West Midlands	36	604	3	88	87	7,147	2.1
East Midlands	33	674	0	0	49	5,932	2.3
Thames/Anglia	42	569	2	36	84	7,082	1.5
Inner London	9	115	4	73	30	2,002	1.3
Outer London	15	280	6	93	47	4,454	1.5
Southern	20	231	2	54	62	5,475	1.5
South Western	43	615	5	112	75	5,987	2.0
England Total	301	4,800	42	825	662	56,723	1.8

4.8. Only 2% of defendants (4 of a sample of 185) passing through the Bow Street/Marlborough Street scheme in London between February 1989 and September 1990 had a diagnosis of mental retardation (Joseph (1992) *Psychiatric Assessment at the Magistrates' Court*, paragraph 5.10). There is little comparable information available from other schemes, but they are generally likely to see only small numbers of defendants with learning disabilities. It is important that, in these cases, needs are properly identified. This will require effective links with local learning disability services, members of which might be encouraged to contribute to diversion schemes on a rota basis (see paragraph 7.11).

Section 136 ("places of safety") and appropriate adults

4.9. Centrally-held information on the use of *section 136 of the Mental Health Act* (removal to a place of safety) (CR 2.9-2.11 and 4.5-4.6; ST 5.13-5.15) relates only to hospital admissions and there is, in any case, thought to be widespread under-recording. Department of Health provisional figures for 1989/90 show (improbably) only two admissions nationally of mentally impaired people. The community, research, and staffing and training advisory groups have all recommended research on the use of section 136 (CR 4.6; RS 6.8; ST 5.15).

4.10. A study of police referrals to psychiatric services in three "places of safety" (CR 2.9-2.13; ST 5.13-5.15) in London found that only 19 (under 6%) of a sample of 326 people were diagnosed as having learning disabilities (including six who were also mentally ill) (Rogers and Faulkner (1987) *A Place of Safety*).

4.11. The community advisory group recommended the adoption of local multi-agency agreements on the operation of section 136 (CR 2.10; ST 5.15; *Mental Health Act Code of Practice* (1990), Chapter 10; Home Office Circular 66/90, Annex A) and the use, wherever practicable, of health or social services facilities, rather than police stations, as places of safety (CR 2.9-2.11; ST 5.14). It would be useful if local agreements, which are growing in number, made special reference to the particular needs of people with learning disabilities (SN 2.4): see extracts from the *Mental Health Act Code of Practice* at *Annex L*. In addition the police may need access, under the Police and Criminal Evidence Act 1984, to an *appropriate adult* who has knowledge and understanding of learning disabilities: see extract from the *PACE Codes of Practice* (revised 1991) at *Annex M*.

- * *WE RECOMMEND that court diversion and assessment schemes develop effective links with local learning disability teams and that, where possible, team members contribute to schemes, possibly on a rota basis.*
- * *WE RECOMMEND that local agreements on the operation of section 136 of the Mental Health Act give special consideration to the particular needs of people with learning disabilities.*

Hospital services

4.12. As noted at paragraph 3.4, the number of NHS in-patients in learning disability beds at 31 March 1991 was 22,100.

Detained patients

4.13. As the hospital advisory group noted, those detained in hospital under the Mental Health Act are only a small proportion (about 7%) of all mentally ill or learning disabled in-patients (HR 2.3). In 1989/90 (Department of Health provisional figures) there were 146 formal admissions of mentally impaired people and 45 of people with severe mental impairment (including 7 in total detained under other legislation). About 60% came under the civil sections (Part I) of the Act, a smaller proportion than for mentally ill detainees (about 85%). Under Part II, there were 60 admissions of mentally impaired offenders and 16 of offenders with severe mental impairment.

Restriction orders

4.14. When a hospital order is made by a court and there appears to be a risk of further offending if the person is set at large, a "restriction order" may also be made. The main effect of this is that the patient may not be allowed leave outside the hospital, or be transferred to another hospital, without the authority of the Home Secretary. He or she may not be discharged except by the Home Secretary or an independent Mental Health Review Tribunal.

4.15. In 1990 67% of detained patients subject to restriction orders were diagnosed as mentally ill and a further 22% considered to have a psychopathic disorder. About 200 restricted patients (10%) had some form of mental impairment (Home Office *Statistical Bulletin*, 16 Dec 1991), a much lower proportion than a generation ago (*cf* 27% of all restricted patients in 1961-65: Kiernan & Alborz (1991) *People with Mental Handicap Who Offend*). There is also a substantial number of conditionally discharged restricted patients with a mental impairment who are subject to statutory supervision in the community. Because of the nature of their disability, combined with the potential risk to public safety, offenders who are mentally impaired and subject to restrictions present special needs in terms of risk assessment, placement and supervision generally.

Regional or district secure beds

4.16. 14 permanent medium secure beds for people with learning disabilities had been provided in Oxford Region through the RSU programme, but the unit there closed in 1992. In accordance with Executive Letter (92)6 (SN, Annex G and paragraph 3.34 above), alternative arrangements have been made for its patients in the community or

in independent hospitals pending reprovision.) There were a further 274 learning disability beds in nine health districts identified by RHAs at 31 January 1991 (*cf* 785 in 1986) as offering some degree of low or medium security. Over 100 of these were in so-called "interim secure units" (not part of the RSU programme). Some form part of specialised services for offenders with learning disabilities, also offering a range of "outreach" facilities (ST 3.8). Six Regions identified no secure places.

High security

4.17. There are about 1,700 high security places at the three *Special Hospitals*. In May 1992 there were 204 mentally impaired and severely mentally impaired patients, all but one being accommodated at Ashworth (Liverpool) or Rampton (Retford, Nottinghamshire):

	Mental impairment*	Severe mental impairment	TOTAL
ASHWORTH	77	10	87
BROADMOOR	1	-	1
RAMPTON	73	43	116
TOTAL	151	53	204

* These figures include some patients with a dual diagnosis of mental impairment and either mental illness or psychopathic disorder.

4.18. There is no unit offering specialised high security services for mentally impaired patients in the south of England. With the occasional exception, patients must go either to Ashworth or Rampton.

4.19. In November 1991 23 Special Hospital patients with a diagnosis of mental impairment (16) or severe mental impairment (7) (including six with a dual diagnosis) had been waiting for more than a year since their responsible medical officer identified them for transfer to more local provision in England (SN 2.18). 14 had been waiting for more than two years. HC(88)43 (see paragraph 3.6 above) stipulates that no Special Hospital patient should have to wait longer than a year for such a move.

- * ***WE RECOMMEND that, at the very least, there should be a re-statement to health authorities that no Special Hospital patient requiring a transfer to a Regional or district facility should have to wait for more than a year. Transfers should normally be effected much more speedily than this. (This should apply equally to mentally ill patients, who were covered by a similar requirement in Health Circular (88)43, and those with psychopathic disorder.)***

Independent provision

4.20. We do not know the precise contribution of the independent sector to hospital services for people with learning disabilities. In 1990/1 there were reckoned to be about 2,800 independent places for patients with a mental illness or learning disabilities (*cf* over 75,000 in the NHS). We have identified over 350 places in independent learning disability hospitals, including some reserved for women or young people. Some of these offer secure provision. Additional learning disability beds are located in hospitals providing for a range of patients.

4.21. A general principle emerging from the review is the need for effective links between independent hospitals and more local services, and for the contribution of the independent sector to be included in wider service planning.

Prison services

Sentenced prisoners

4.22. Recent studies have suggested a low prevalence of learning disabilities among sentenced prisoners (much lower in fact than some earlier studies: Kiernan and Alborz (1991) *People with Mental Handicap who Offend*):

- i. Gunn (*op cit*) found a diagnosis of "mental retardation" in less than 1% of men and in 2% of women. Based on a sentenced prison population of about 40,000, these findings point to about 400 prisoners with learning disabilities;
- ii. a census by medical officers in 1986 suggested a diagnosis of mental impairment or severe mental impairment in 5% of sentenced prisoners serving at least 6 months (DHSS/Home Office (1987) *Interdepartmental Working Group of Officials on Mentally Disturbed Offenders in the Prison System in England and Wales*, Annex C);
- iii. a detailed needs assessment in one Region used a prevalence of learning disabilities among the prison population of 2.5% (University of Birmingham Centre for Research and Information into Mental Disability (1992) *Services for People with a Mental Impairment: a Strategy Review Completed for the West Midlands Regional Health Authority*). This drew on an earlier study by Bluglass (1967), which found that 2.6% of sentenced prisoners in a Scottish prison had a learning disability and a further 11.6% had a borderline disability.

Learning difficulties among prisoners

4.23. Asked recently about the percentage of prison inmates with learning *difficulties*,

the Minister of State at the Home Office replied:

Records of the number of prisoners with learning difficulties are not held centrally. In the White Paper, *Custody, Care and Justice* (Cm 1647), the Government stressed that the first priority must be to identify and provide help for those prisoners who have difficulty reading or writing and who are unable to do simple arithmetic. The national prison survey undertaken in 1991 indicated that 43 per cent of prisoners had left school before the age of 16, prisoners had higher truancy rates than the general population, and 43 per cent of prisoners had no qualification when they came in to prison (*House of Commons Official Report*, 28 Oct 1992, WA 654).

4.25. The majority of prisoners with learning difficulties or very basic educational needs will not have learning *disabilities* in the clinical sense. Careful definition is of the essence (see, eg, BBC TV *Public Eye*, 12 June 1992). However, as Gunn (*op cit*) noted:

A good remedial education service would aid the assessment of mentally handicapped inmates and could also benefit those prisoners who are not mentally handicapped but have serious difficulties with literacy or numeracy.

Remand prisoners

4.26. Among a sample of 568 male remand prisoners at Brixton referred for medical reports, Grounds (*Mentally Disordered Remand Prisoners*, 1991) found a diagnosis of "mental retardation (without accompanying psychotic disorder)" in only 15 cases (5%).

4.27. Of a sample of 196 female remand prisoners at Holloway referred for psychiatric examination, 19 (10%) had a mental handicap (9 definite; 10 borderline) (*ibid*). Of these, 15 (most of whom had been charged with relatively minor offences) were referred for second opinions outside. Only one was ultimately imprisoned. Four were made the subject of hospital orders under the Mental Health Act and the remainder were returned to the community with non-custodial disposals.

4.28. At the time of the Grounds study (1989) referrals for psychiatric observation or reports were equivalent to an annual rate of over 2,200 at Brixton and 900 at Holloway. These prisons serve much of south east England.

4.29. Kiernan and Alborz (*op cit*) have pointed to a need for a prevalence study among the general remand population (*ie* not only those referred for reports): see paragraph 8.2.

Prison health care

4.30. Following the Efficiency Scrutiny of the Prison Medical Service (1990), the future policy will be to contract in prison health care (DMPS (1991) *Contracting for Prison Health Services*; OV, Annex C). The Health Care Service for Prisoners (as it now is) will become a purchaser rather than a provider. We consider the implications of these changes for prisoners with learning disabilities at paragraphs 6.15-6.17.

Chapter 5:

Children and adolescents

5.1. The age of criminal responsibility is 10.

5.2. In an earlier discussion paper on services for children and adolescents (SN 4.14-4.20), we emphasised that:

- i. relevant specialised services for young people should be seen, as far as possible, as part of a much wider service embracing a range of agencies and type of provision (health and local authority child care and mental health services, education, Youth Treatment Centres, *etc*);
- ii. the balance struck between the individual services should be in the best interests of the person concerned (one of our "basic requirements" for "special needs" services: SN 2.2; 4.19 and paragraph 3.31 above); and
- iii. where necessary, and especially where secure accommodation is used safeguards are satisfactory and careful regard is paid to differing (*eg* men health/child care) legislative requirements (SN 4.19; Utting (1991) *Children in Public Care*, paragraphs 4.48-4.55: SN, Annex J).

5.3. We said that we should be giving further consideration in this report to services young people with learning disabilities (SN 4.20), a key feature of which is development at local level of well coordinated social, health and education components. These should be designed:

- i. to emphasise the needs of children *as children* (see below);
- ii. to prevent or reduce the effects of disabilities;
- iii. to ensure the early identification, assessment and regular reassessment of individual needs; and
- iv. wherever practicable, to meet those needs.



5.4. The *Children Act 1989* introduced important new provisions for children's services, including for children with disabilities: see *The Children Act 1989 Guidance and Regulations - Volume 6: Children with Disabilities*. Work with children in the context of the Act must be based on the notion that children with disabilities are "children first" (*ibid*, paragraph 1.6). Other key principles are that:

- i. the welfare of the child should be safeguarded and promoted by those providing services;
- ii. access for all children to the same range of services should be promoted;
- iii. the importance of parents and families in children's lives and as partners with local authorities and other agencies should be recognised;
- iv. the views of children and parents should be sought and taken into account (*ibid*).

Specific policy developments since 1988

5.5. In 1988-9 the Department of Health reviewed its policies for child and adolescent learning disability services. A draft guidance paper was prepared, but this was overtaken by publication of the community care White Paper, *Caring for People* (Cm 849, 1989), and the preparation of guidance on the Children Act (see above). The draft 1991 circulars are concerned almost entirely with adult services (the local authority circular exclusively so). *Needs and Responses* (*op cit*) looked only at adult services, as did the Mansell group, although the latter has touched on the transition to adult services and the need to plan for that process. In these circumstances, we have felt it important to take account of relevant aspects of the 1988-9 review.

The assessment process

5.6. There should be a comprehensive, multi-disciplinary assessment of all children in whom learning disabilities are suspected or detected. Early identification, usually by the NHS, is important to enable provision to be made for a child's specific social, health and educational needs and to offer support and counselling to the family. *Progress must be reviewed regularly* to ensure that individual programmes reflect a child's changing and longer-term needs, including those in adolescence and adulthood.



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Education Act 1981

5.7. The assessment process was augmented by the Education Act 1981 (see paragraph 2.12). This requires health authorities to inform the parent of a child under five of any special educational needs (SEN) they consider that he or she may have. After discussion with the parent, they must also inform the local education authority (LEA) which has a duty to assess children considered to have SEN. Assessed needs must be recorded in a **"statement"** of SEN. If a child is under two, he or she may be assessed by the LEA if the parent agrees and must be assessed at the parent's request.

5.8. About 16% of all pupils are estimated to have SEN at any one time, although such needs vary considerably. Special schools cater for 1.3% of the total school population. 24% of the total SEN population have severe learning difficulties (*ie* within the meaning of the Act). About a third of these are multiply handicapped. 8% of the total have emotional or behavioural disturbance (Audit Commission/HMI (1992) *Getting in on the Act*).

5.9. Department of Education Circular 22/89 and its Addendum (DES letter, 10 Mar 1992) give detailed guidance on procedures for assessments and statements of SEN, including the role of health and social services staff and provision of health and social care needs identified in statements. It takes account of provisions in the *Education Reform Act 1988*, which introduced the National Curriculum (which applies to children with statements unless individual modifications or exemptions have been made), local management of schools (*ie* delegated budgeting) and grant-maintained ("opted-out") schools.

Cultural factors

5.10. Those assessing SEN should bear in mind that linguistic or cultural factors may mask a child's potential (see paragraph 2.13). *Differences of language, culture or social background are not in themselves causes of SEN* (SN 3.15; Inner London Education Authority (1985) *Equal Opportunities for All?* (the Fish report)).

Audit Commission/HMI report and 1992 White Paper

5.11. A recent report by the Audit Commission and Her Majesty's Inspectorate of Schools (*Getting in on the Act, op cit*), based on a study in 12 LEAs, raised a number of general concerns about SEN provision, including delays in issuing statements. It also highlighted a "lack of clarity as to what constitutes special educational needs". The Government has said that it "remains committed to the principles of the 1981 Act, but shares the concerns...about the way it works" (DFE press release 209/92). It has indicated in the White Paper, *Choice and Diversity* (Cm 2021, 1992), that LEAs will retain their responsibility for assessments and statements (*ibid*, paragraph 9.3), but has published proposals, for comment by September 1992, for improving the arrangements for these (DFE (1992) *Special Educational Needs: Access to the System*).

Identifying behavioural difficulties in young children

5.12. The means of identifying behavioural difficulties in learning disabled children (NR 2.1-2.7) are likely to depend on the pattern of their service contacts in the early years. They often first become apparent in a nursery class or at school, although pre-school contacts with, for example, general practitioners or health visitors may lead to earlier identification (Sloper (1989) *The Manchester Down's Syndrome Cohort Study*).

5.13. It is important that early signs (including the possible difference between behaviour at and away from home) are not ignored: behaviour that can be tolerated in a small child often becomes unacceptable by adolescence. Staff in a range of agencies will need to know what specialised services are available locally, or if necessary, at supra-district level if a child does not respond to an initial intervention programme (see paragraph 5.15). They should also be able to offer support to parents (CR 3.44) and siblings (Fairbrother (MENCAP, 1989) *I Was the Lucky One*). There are signs of increased exclusions from school of "difficult pupils", although not all of these children have emotional or behavioural difficulties. The need for enhanced special provision might be demonstrated through research (Audit Commission/HMI, *op cit*, paragraphs 109-110, and paragraph 8.4 below).

5.14. The 1989 review paper suggested a checklist for agencies making decisions about placements (itself a refinement of advice in *Helping Mentally Handicapped People with Special Problems*, *op cit*, Chapter 7):

- i. what kind of help would be needed (usually in the form of "shared" care between the family and the health and/or social services) to enable the child to continue to live at home?
- ii. if, despite professional support and respite care, the child cannot remain at home, is placement with a substitute family possible, including, if necessary, longer-term fostering? What are the views of the natural parents?
- iii. if fostering is not feasible, is a residential school or other small unit available local (or, if absolutely necessary, further afield)?
- iv. if so, what arrangements can be made for daily education ... weekends, holidays the maintenance of family links? (Advice on maintaining links with parents was given National Development Group Pamphlet 2, *Mentally Handicapped Children: A Plan of Action* (1977, reprinted 1985), paragraphs 70-81);
- v. what is the child's potential and what arrangements can be made to plan for the transition to adolescent or adult services?
- vi. whatever the nature of the placements, what are the continuing needs of the family?

Service responses

5.15. Given the importance of early intervention when behavioural difficulties are apparent, we see advantages in a small, specialised local or supra-district service. This would have some conceptual similarities with the model described for adolescent forensic psychiatric services in our earlier report (SN, Discussion Paper 6). *Helping Mentally Handicapped People with Special Problems* described a unit (since closed) which offered planned periods of multi-disciplinary assessment and treatment for a small number of children, together with individual educational and day support. There was also local "outreach" work and advice to a range of staff over a much wider area. Parents were actively involved. We should not wish to be prescriptive about the pattern of service delivery, but we do regard as a bottom line the ability to respond in an effective, coordinated way to a range of challenging individual needs.

5.16. It is sometimes difficult to find placements for children who acquire a label as being "behaviourally disturbed" or having "challenging behaviour". Equally though, there may be practical problems or even dangers in providing care in settings which cater also for other physically frail children. *Helping Mentally Handicapped People with Special Problems* mentioned two NHS units, providing local residential care, which had found it possible to do this, but there are instances where difficulties have arisen, including problems for staff and parental concerns about the behaviour and appearance of some children (see, eg, Brimblecombe and Russell (1988) *Honeylands*). These examples highlight the complex balance between individual needs and those of other children and parents, and the importance of diversity in local provision.

- * *WE RECOMMEND that agencies working with children with learning disabilities/difficulties develop a coordinated range of specialised services, sensitive to the wishes of parents and children alike, to meet in the round the needs of those who develop behavioural difficulties.*

The "bridge" of adolescence

5.17. In our earlier report (SR, *Discussion Paper 6*) we cited the Health Advisory Service report on adolescent psychiatric services, *Bridges over Troubled Waters* (1986):

Adolescence represents a time of great developmental significance. For the vast majority, the "bridge" between dependent childhood and independent adulthood is negotiated more or less smoothly. For a few, the transition period is stormy and help is needed to prevent long term personal damage (*ibid*, *Preface*).

5.18. By adolescence, a child's disabilities may have been manifest for some years. However, those disabilities may aggravate the developmental and social challenges that most teenagers face and, indeed, predispose to psychiatric disorder. Young people with mild learning disabilities are often easily "led" by their peers and may, as a result, drift into offending or other anti-social behaviour.

Offending

5.19. We noted in our earlier report that, per head of population, offending among 14-17 year olds is higher than for any other age group (ST 4.15). It is at this point that so many people first come into contact with the criminal justice system and where it is crucial that assessment and diversion mechanisms help to ensure that young people with learning disabilities do not get caught up unnecessarily in a criminal justice spiral. That is not to say, however, that they should automatically be protected from the unacceptable consequences (including the legal consequences) of their behaviour. There is a balance to be struck in every case. A sensitive disposal, which places a young person under some obligation, may be preferable to a discharge which simply leaves him or her to drift and possibly re-offend.

Youth courts

5.20. The *Criminal Justice Act 1991*, which comes into force on 1 October 1992, recasts juvenile courts as "youth courts" and extends their jurisdiction to 17 year olds (who were previously covered by adult courts). The Act makes courts' sentencing options more flexible, strengthens their power to involve parents, and reforms arrangements for the remand of young people under 17. The arrangements are described in detail in Home Office Circular 30/1992 (Local Authority Circular (92)5). *School Reports to the Courts* (DFE, 1992) contains guidance on the provision by schools of reports on pupils charged with offences.

Key considerations

5.21. The 1989 review paper summarised the key features of adolescence and its implications for a range of services:

During this period the family's task may become more difficult and stressful, with additional support and respite care being required. Sometimes a move to residential or foster care, or to a more independent form of living, may be necessary. Some adolescent start work, although most are likely to move on initially to further education and training.

There is now fairly widespread recognition that adolescents represent a distinct planning group. This is not always reflected in actual service provision, nor, in any case, are there neat borderlines between services for children, adolescents and adults with [learning disabilities]...The period of adolescence is defined by development rather than age, its chief characteristics being a dramatic acceleration of physical development, accompanied by emotional and social changes. For [learning disability] services, this means that "adolescence" may, in practice, range from early teens to mid-twenties (or even later). Coordinated planning is desirable to ensure that adolescents do not fall between child and adult provision. Similarly, the eventual transition to adult services (which may involve several distinct processes) must be managed carefully so that an individual is not "lost" to the system or deprived of services that he or she may continue to need.

Provision for adolescents...needs to be flexible and varied. In addition to basic service requirements, account should be taken of the more personal needs of this group, including the desirability of peer support and practical considerations such as availability of transport. Wherever possible, adolescents should be enabled to take part in usual teenage activities. Ideally these should be a progression from earlier involvement in ordinary childhood experiences, but they occur at a time when, in the face of profound changes, individual self-esteem may be low and awareness of handicap correspondingly high. Psychiatric, genetic and psychosexual counselling should be available to help deal with particular problems or risks that may arise, including emotional or behavioural difficulties. The training of staff to recognise these special needs and ready access to other specialised or primary care services, such as those dealing with family planning, AIDS or substance misuse, may also be needed.

5.22. Such considerations apply generally to all adolescents with learning disabilities, although, as the Court report (DHSS/Welsh Office (1976) *Fit for the Future*) noted 16 years ago, the need for separate adolescent facilities is likely to be greater among those with chronic socially disruptive behaviour than among other groups of young people. Flexibility is important. Adolescents may need access to specialised learning disability

or mental health care services (or both), to general medical services, and to a range of specialised professional help or counselling, including, in the case of offenders, the probation and other criminal justice services. Wherever possible, care should be on a day or out-patient basis, but access to in-patient accommodation, including local or supra-district secure provision, may be necessary if behaviour is severely problematical.

- * **WE RECOMMEND** that agencies develop a joint approach to ensuring that adolescents with learning disabilities who offend or appear to be at risk of offending have access to a range of general and specialised services suitable for their age and stage of development and that they do not get drawn unnecessarily into the criminal justice system.

Sex education, consent and abuse

5.23. Problems of developing sexuality in adolescence may include, as we noted in our earlier report, difficult questions of consent and possible **abuse** (either as victim or perpetrator):

People with learning disabilities may need support to help them understand their sexuality and close relationships with others. This is especially so in adolescence. The views of families and the people concerned should be taken into account, including [on] the sensitive handling of problematic questions, such as consent and family planning. In the context of sexual abuse, it is important to emphasise that a person's sexual offence may not have been perpetrated with his full understanding or intent. Some people with low intellectual ability have little concept of social misdemeanour or morality or of the illegality of their offence. Their treatment should be determined accordingly. People with learning disabilities may, because of their lack of understanding or awareness, also become victims of sexual abuse (SN, *Discussion Paper 4*).

5.24. Young women with learning disabilities may have particular needs relating to **sex education** or arising from sexual activity (SN, *Discussion Paper 8*). Advice should be available on a range of issues, including those of **consent** (Department of Health, *Handbook on Contraceptive Practice*, Chapter 9; Day, *Contraception and sterilisation for people with learning disabilities* in *British Journal of Sexual Medicine*, Autumn 1991). Some of the wider legal aspects of the ability or otherwise of children and adults with severe learning disabilities to give valid consent (including to treatment) are likely to require further attention: see, eg, Law Commission Discussion Paper No 119 (1991) *Mentally Incapacitated Adults and Decision-Making: An Overview; Re B (a minor)* [1988] AC 199; *Re F* [1990] 2 AC 1; Mental Health Act *Code of Practice (op cit)*, paragraphs 15.16-15.20.

5.25. Victims of sexual abuse should be managed within the terms of the child protection policy set out in *Working Together under the Children Act 1989* (Department of Health, 1991). Our earlier report drew attention to the National Children's Home study (1992) on children and young people who sexually abuse other children (SN, *Discussion Paper 4*).

Preparing for the future

5.26. If a young person is subject to a statement of SEN, a formal review must be initiated by the LEA at the age of 13-14 to determine whether he or she should stay at school until 19 or what placement might be suitable on leaving school. Parents and the person concerned are usually involved in this process. Others taking part would usually include representatives of adult training centres and special needs units, as well as staff from health and social services and other (sometimes voluntary) agencies.

5.27. Individual services will often undertake their own assessments, but they need to be aware of the school assessment and have access to other records of a young person's development, progress and self-help capabilities. Under section 5 and 6 of the *Disabled Persons (Services, Consultation and Representation) Act 1986*, LEAs must notify local authorities of disabled school leavers and local authorities are required to assess their needs.

5.28. Options for school leavers include *further education* (see Her Majesty's Inspectorate (DES, 1989) *Students with Special Needs in Further Education: Education Observed 9*), *full or sheltered employment*, *training for employment*, and specialised provision (including ATCs and SNUs). Opportunities may be needed to attend adult education classes or to continue with skill acquisition, therapy or language programmes. Continuing access to short-term or respite care (which often seems to disappear around the age of 16) may also be required.

5.29. Despite the "label" referred to at paragraph 5.16, it is sometimes easier to identify suitable adult placements for young people with moderate to severe disabilities than it is for those with mild disabilities (particularly offenders) who often find it difficult to secure a job or then to hold it down. We noted in our discussion paper on brain injury (SN 4.2-4.3) the need for effective *liaison with, and guidance for, potential employers*. This applies equally to people with learning disabilities.

5.30. *It is always important to look ahead.* Short-term options (eg further education) need to have a purpose to them, with some idea, subject to changing needs, of where the person's longer-term future may lie. Where continuing residential care is thought to be necessary, or the young person continues to live at home, the possibility of eventually living more independently (for example, after the death of a parent or if behaviour becomes less problematic in adulthood) should also be considered.

Chapter 6:

Service issues for the future

The need for a multi-agency focus

6.1. This review has recommended the development of a multi-agency focus in each area for mentally disordered offender services, with links to the *area committees* that are being established to bring together criminal justice agencies (*Custody, Care and Justice* (Cm 1647, 1991), paragraph 1.13; CR 3.30-3.32). These arrangements need either to include a clear focus for relevant learning disability services or to provide effective links with those services.

- * *WE RECOMMEND that local multi-agency groups for mentally disordered offenders and area committees for the criminal justice system should provide a clear focus for, or maintain effective links with, relevant services for people with learning disabilities.*

Needs assessment

6.2. Given that insufficient is known about precise service levels or needs for offenders with learning disabilities and similar patients, the starting point for future service plans is an effective needs assessment. Needs will in any case vary from one location to another. The hospital advisory group speculated as to the possible national requirement for levels of secure provision for people with learning disabilities (HR 7.9-7.10), but, as we noted in our earlier report (SN 2.22), *these are not targets and were not intended to obviate the requirement for proper local needs assessments.*

6.3. In terms of mentally disordered offenders as a whole, this process has been given a strong boost by NHS Management Executive Letter (92)24 (see *Annex N*) which asked Regional Directors of Public Health to conduct a needs assessment, in conjunction with other agencies, with particular emphasis on requirements for various levels of secure provision. This was to include the needs of people with learning disabilities.

6.4. The intention is that this will be an annual exercise, broadened and refined in the

light of experience to cover the whole range of health and social services for mentally disordered offenders and similar patients. It is clear from the initial assessments that many Regions are already looking at the implications for learning disability services (see, eg, Northern Regional Health Authority (1992) *Assessment of Health Care Needs: Mentally Disordered Offenders in the Northern Region*), although generally it will be necessary for future assessments to give these more specific attention. An earlier assessment for one Region (University of Birmingham, *Services for People with a Mental Impairment, op cit*) may provide a helpful guide: see *Annex O*. In the meantime the Department of Health is following up the initial assessments with Regions on an individual basis.

- * *WE RECOMMEND that future needs assessments (carrying forward work done in the light of NHS Management Executive Letter (92)24 and undertaken on a multi-agency basis) should give more specific attention to the needs of people with learning disabilities.*

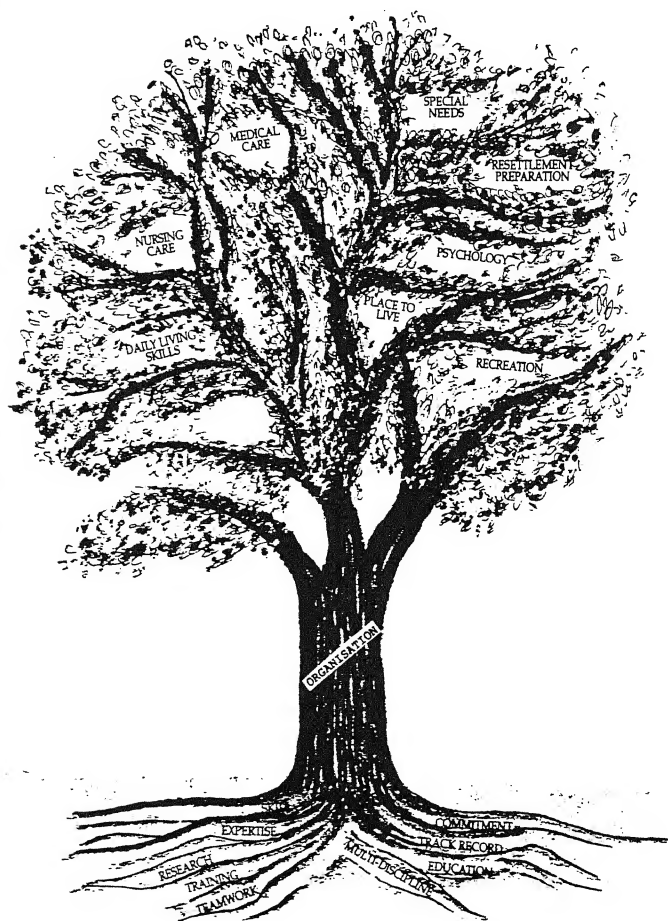
The development of secure and associated "outreach" services

6.5. Assessments must take account of those people in prison who might have been diverted to health or social services, those likely to be identified at the court or pre-court stage, and patients in Special Hospitals who may or may not need a high level of security.

6.6. More work needs to be done to consider the implications of this review for patients needing or currently being treated in *high security*. This will be one of the tasks of the working group announced by the Secretary of State for Health following the Ashworth Hospital inquiry (see paragraph 3.37). There has been a gradual reduction in the number of Special Hospital patients with mental impairment or severe mental impairment (from 249 in 1987 to 188 in 1991). The effect of this is being felt in some areas where the local or supra-district services are having to find placements for a more challenging group of people than before. Their needs (though not requiring high security) are often highly resource-intensive, calling probably for the development of a specialised service which is able to offer a variety of residential or community responses to highly individual circumstances.

6.7. Existing *medium secure* psychiatric provision is unsuitable for people with learning disabilities, who, in any event, require a different therapeutic approach and whose needs militate against the 18-24 month treatment philosophy usually applied by Regional Secure Units. There must therefore be separate learning disability provision, although there may be scope for some "campus" type developments that provide specialised care in a discrete unit, while drawing on a number of common services and maintaining active community links.

6.8. Units that could loosely be described as "medium secure" (though often relying more on high staffing ratios or extensive grounds than on significant visible security), or,



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indeed, more local units, have the potential to become valuable centres of expertise, provided that the in-patient service is matched by a full range of *"outreach" services*. Between them, these should be able to provide a full range of care including, as necessary, practical skills training, further education, counselling and behavioural programmes, together with access to residential, occupational and recreational facilities. Again, such developments have clear resource implications, but they would also have a preventive function with possible savings, as well as health and social gains, in the longer-term. As we say at paragraph 7.4, the cost of doing nothing is often greater over time than effective intervention.

6.9. It is not possible at present to provide firm estimates for secure provision for people with learning disabilities, but at least it is now firmly established that the medium secure programme does include such services (Annex F; SN 2.21). We consider that a learning disability element should be identified specifically in new Regional bed targets to be set in the light of the review (HR 5.36; SN 2.21-22). Allied to this would be a need to demonstrate how the secure service would fit into a wider strategy for people with learning disabilities. We anticipate that the NHS generally may need guidance on this and on such aspects as staff mix, design and outreach services.

- * ***WE RECOMMEND that Regional targets for medium secure beds should include a learning disability element specifically identified and related to a wider Regional strategy.***
- * ***WE RECOMMEND that the Department of Health issues practical guidance on the development of medium secure provision for people with learning disabilities.***

Identifying the needs of offenders with mild to moderate or borderline learning disabilities

6.10. This review has emphasised the use of non-secure, community services wherever possible. We have not attempted in this report to set out again the range of services that may be needed. Many of the considerations in the report of the community advisory group apply equally to people with learning disabilities, while the draft 1991 circulars (at Annexes D and E), together with Mr Dorrell's policy statement (Annex C) describe the future direction of general learning disability services that the Government envisages. Key issues that arise in our own area of interest include the different management of mental illness and learning disability services and the likely requirements for some specialised learning disability services: for example, to provide for rehabilitation or other care for offenders or similar patients who cannot be managed in mainstream community services.

6.11. ***We are concerned about the particular needs of the majority of offenders with learning disabilities who have borderline or mild to moderate disabilities.*** Services for them are often not identified specifically in agencies' plans and they often fall between services:

People with mild mental handicap with disturbed behaviour often seem to fall between mental illness services, forensic psychiatric services, [learning disability] services, social services, probation and the courts. Sometimes services are not sufficiently well developed to cope effectively, and sometimes liaison between services is ineffective or absent...Similar problems are posed by those "borderline" individuals who are intellectually dull, show a marked inadequacy of social adjustment and share some of the difficulties in coping with life. The significance of mild [learning disabilities] may not be recognised in some people who come to the notice of the social or probation services due to their offending behaviour (NR 5.4).

The "competence trap"

6.12. It is unlikely that such offenders will come within the scope of the Mental Health Act and prison will often be an unsuitable disposal. Even if their needs are identified, they may not be regarded as requiring much of a response. And there is a further dilemma, which has been well described by North Western Region's Mental Handicap Advisory Group in *Caught in the Competence Trap* (1990):

Learning [disabilities] are specific to situations. People with moderate learning [disabilities] may for example learn to disguise their difficulties by avoiding demands that reveal them as different from others. We have also identified a *competence trap* whereby competence shown in one setting leads to placement decisions that underestimate the support needed in the new setting and in different areas. This can lead to experience of failure (*ibid*, p2).

Service features

6.13. *Caught in the Competence Trap* (pp 7-10) made a number of positive recommendations for people with mild to moderate learning disabilities which, in summary form, we endorse:

i. health, social services, education, employment and criminal justice agencies should recognise the existence of this client group, "affirm their eligibility to services where they need them" and reflect these in their purchasing plans;

ii. there should be better multi-agency working, with clear responsibilities established for the coordination, purchase and provision of such services;

iii. a starting point may be the assessment of young people with specific learning difficulties leaving full-time education (see paragraphs 5.26-5.27 below), to be followed by a more detailed multi-agency needs assessment and other work to raise the profile of the group on a multi-agency basis, including the dissemination of good practice;

iv. target dates should be adopted by which people with mild learning disabilities have access to services which meet their own particular needs, including access to a range of other health and social services.

- * *WE RECOMMEND that agencies should develop joint plans to identify and provide for the specific needs of people with mild to moderate learning disabilities, including in particular those who offend or are at risk of offending.*

6.14. Serious violence is uncommon among offenders with learning disabilities, but *sexual offences* are over-represented and a significant proportion of *arsonists* have learning disabilities. Recidivism is common. Therapeutic responses to these tendencies need to be developed. More research is needed (see paragraph 8.3).

Prison care

6.15. Prison care for mentally disordered offenders generally was considered in detail in the *report of the prison advisory group*. The present review has supported the concept of contracting in a full mental health care service to prisons (OV 20). Our own earlier report recommended that:

contracts for the delivery of mental health care services to prisons should include a requirement for staff to facilitate, as necessary, arrangements to meet the additional special needs of patients (SN 2.29).

6.16. Accordingly, we consider that, for prisoners who need them, there should be access to all the necessary health and social care elements of a learning disability service, as well as other services, such as education. In some cases diversion to health and social services may need to be considered, for example, if the person is clearly vulnerable or subject to victimisation.

6.17. There is evidence that learning disabilities are "managed sometimes as bad or difficult behaviour" (Gunn, *op cit*). Better training of prison staff to recognise these may be needed. We recommended in our earlier report that:

"special needs" (in particular those of substance misusers, prisoners with moderate learning disabilities and those vulnerable to suicide) should be reflected in standards set for the health care aspects of the reception process (SN 2.27).

Other key issues

Care programmes

6.18. We have recommended that the "care programme" arrangements in Health Circular (90)23/Local Authority Circular (90)11 (see *Annex P*) should be extended explicitly (with any necessary modifications for the particular client group) to discharged prisoners with learning disabilities (SN 2.38-2.39). Such arrangements should apply also to offenders with learning disabilities being discharged from in-patient care (as they do already to those at Special Hospitals).

Race and culture

6.19. In our earlier report we noted the widespread perception that people with learning disabilities from ethnic minorities often do not receive effective support from local services (SN 3.14; Ward, *Double discrimination in Health Service Journal*, 18 April 1991). In some instances, this seems to be because they do not seek support. There are, for example, far fewer black people in ATCs than might be expected.

6.20. *A discussion paper on issues of race and culture, prepared during this review, is being published for consultation.* This recommends, among other things, a much more positive approach to equal opportunities policies, the explicit consideration of race and culture in professional and vocational training, and the involvement of ethnic minority communities in the planning, development and monitoring of services. The draft local authority circular on learning disabilities (see paragraph 3.13 above) emphasises that services must be arranged "on an increasingly individual basis, taking account of age, needs, degree of disability, personal preferences..., culture, race and gender". It is important therefore that services are - *and are seen to be* - both suitable for and acceptable to ethnic minorities.

Adult education

6.21. Chapter 5 referred to links with LEAs in the provision of services for children and adolescents. It is important that such contacts are maintained, where necessary, into adulthood.

6.22. Education for people in secure provision was considered in a National Institute of Adult Continuing Education conference report, *Educational Provision in NHS Forensic Secure Services* (1991), and in the report of the staffing and training advisory group (ST 3.71; 4.71).

Chapter 7:

Resource issues

7.1. This chapter identifies some of the *financial, staffing and training issues* for learning disability services. These were addressed in the broader context of the review by the reports of the finance and staffing and training advisory groups. We have not sought to repeat their very detailed analysis. However, we recognise (as must the various agencies concerned) that the involvement of learning disability services is an additional factor in a complex picture.

Report of the finance advisory group (June 1992)

7.2. The report of the finance advisory group considered the cost of recommendations made by the earlier service advisory groups, including the need for a more integrated system of financing across a number of agencies. It emphasised the importance of:

- i. breaking down disincentives to achieving suitable placements (FN 2.11; Bynoe (MIND, 1992) *Treatment, Care and Security*);
- ii. the responsibility of district health authorities, subject to performance management and monitoring arrangements at Regional and national level, for purchasing (or ensuring the purchase of) the full range of specialised services assessed as being needed for their populations (FN 5.7);
- iii. as recommended in our earlier report (SN 2.9-2.15), ensuring that mechanisms exist to maintain specialised services that will continue to be needed, possibly on a supra-district or supra-Regional basis; and
- iv. continuing to earmark funds for the development of medium secure services (FN 3.10).

7.3. For local authorities, increases in *supplementary credit approvals* for capital development and in the *mental illness specific grant* were proposed. We envisage that elements of the latter, if set aside for mentally disordered offenders, might be applied to suitable services (eg assessment and diversion schemes) which also provide for people with learning disabilities.

The "iceberg" effect: the cost of failing to provide effective services

7.4. The finance group highlighted, as has the Mansell group, the potential human and resource cost of *not* providing timely and effective care. This includes what Mansell, invoking the characteristics of an iceberg, describes as "the hidden costs of failure to develop local services, such as the costs of handling crises and placement breakdowns". The finance group expressed itself as follows (FN 2.4-2.5):

Mentally disordered offenders who are not imprisoned because of the relatively less serious nature of their offences may pass repeatedly through the hands of the police and courts - the so-called revolving door syndrome. In terms of the life-time cost to the public purse of providing for a given mentally disordered offender, inappropriate criminal justice disposals almost certainly represent a less than efficient (and certainly ineffective) use of public money.

We recommend that planning decisions about services for mentally disordered offenders, at local and national level, should take account of the cost to all agencies which work with this group. This includes the future cost of deterioration in a person's condition when effective early intervention is denied.

- * *WE RECOMMEND that, in planning services for, and delivering services to, offenders with learning disabilities, agencies jointly take account of individuals' longer-term needs, including the social, clinical, educational and resource implications of failing to respond effectively.*

General expenditure on learning disability services

7.5. Total expenditure on NHS *in-patient hospital services* for people with learning disabilities (excluding Special Hospitals) was £642.1 million in 1990/1 (FN 5.11). Revenue expenditure on the Special Hospitals (8-9% of whose patients have mental impairment or severe mental impairment) was £90 million in 1991/2. Roughly a third of all *joint finance* allocations are spent on learning disability services. These amounted to £51.5 million in 1989/90 (FN 6.11).

7.6. Gross expenditure by *local authorities* on learning disability services in 1989/90 was at least £525 million (FN 6.9). In addition, *dowry payments* of £12.3 million were made by health authorities to local authorities in respect of long-stay hospital patients discharged to community care, while £139 million was provided by *social security* payments for residential care (FN 6.10). From 1993/4 the latter will progressively be transferred *en bloc* to central local authority grants, a development whose possible implications for mentally disordered offenders will be addressed by the Steering Committee in its final report. Department of Health grants to *voluntary bodies* in the learning disability field totalled £612,000 in 1991/2.

Report of the staffing and training advisory group (June 1992)

7.7. The staffing and training advisory group (see full list of recommendations at *Annex Q*) examined in detail the present and projected staffing contributions to services for mentally disordered offenders. Pending the present report, the requirements for staff working with people with learning disabilities were excluded in a number of instances (ST 1.4).

7.8. Key points to emerge from the staffing and training group report included:

- i. the difficulty of identifying precise contributions to work with offenders (other than that in secure services) due to these being subsumed very largely within mainstream provision (ST 1.8);
- ii. the importance of future staffing requirements being based on the outcome of needs assessment rather than "norms" (ST 1.9) (although, except for medical consultant posts (see paragraph 7.13), the latter have not generally been applied to learning disability services in recent years: see *Government Response to the Social Services Committee* (1985) (*op cit*), Annex 2, paragraph 11);
- iii. a mainly (though not exclusively) "employer-led" approach to specifying training needs (ST 4.4).

Implications for learning disability services

7.9. The above points apply equally to learning disability services. Another consideration is that because of the continuing (often life-long) service commitment that most learning disabled people require (SN 2.38), additional interventions may not always be needed in individual cases in the way that they might be if someone is found to be mentally ill. The offending may, in service terms, be largely incidental (although obviously in some cases a special response may be called for, possibly involving the criminal justice services. We have commented above on the possible longer-term cost of failing to intervene effectively).

7.10. The main areas where additional staffing will be needed are:

- i. relevant specialised, including secure, services;
- ii. the contribution of learning disability services to the range of mechanisms for identifying, assessing and diverting offenders.

7.11. Given the relatively small number of offenders with learning disabilities, "on call" or rota procedures are usually likely to be sufficient to ensure that the local services are involved where necessary at the earliest opportunity. However, as implied at paragraph 2.8, mental health care and other staff involved on a more regular basis with

(for example) diversion schemes, as well as the police, probation and prison staff (see paragraph 7.32), will need to be trained to recognise learning disabilities so that effective assessment and intervention can be arranged.

Staff working with offenders with learning disabilities

Medical staff

7.12. In 1990 there were 179 consultants in learning disabilities in England and Wales. According to Department of Health figures, based on RHA returns, there were 49 senior registrars and 33 registrars (although the Royal College of Psychiatrists put the number of senior registrars at 61) (ST 2.2). The national target for learning disability senior registrars by March 1994 is 96 (ST 2.8). The staffing and training advisory group has estimated that an additional 80 consultant forensic psychiatrists and 175 other consultants, together with training posts, may be needed for work with mentally disordered offenders over the next 5-10 years (ST 3.34). These figures do not take full account of the requirement for medical staff to work in new learning disability services, but they take do broadly allow for medium secure needs (within a minimum requirement of 1500 medium secure beds nationally for all types of patient: HR 5.36). Precise estimates must be based on needs assessments. There must be effective links between services for offenders with learning disabilities and the general, forensic and child and adolescent psychiatric services, and possibly scope for joint posts covering more than one specialty.

7.13. A minimum goal of 1 mental handicap consultant per 200,000 population, set by the Royal College of Psychiatrists in 1975, has not been met nationally, although it has been achieved in some districts. The pattern of learning disability services has changed significantly since the mid-1970s and, with it, the range of skills that consultants and medical staff have to use. We understand that the Royal College of Psychiatrists is re-examining its 1975 guideline.

7.14. Only a small number of medical staff are currently working with learning disabled patients in low to medium secure services. Most do so on a sessional basis. There are four consultants in learning disabilities at Rampton Special Hospital. Many more doctors work with learning disabled offenders and similar patients in other settings. ***General practitioners*** and other primary care staff (*eg* dentists) have a particularly important role (CR 3.43; ST 2.14-2.16).

7.15. The report of the staffing and training advisory group considers the role of medically-trained ***psychotherapists*** in services for mentally disordered offenders generally (ST 2.17-2.18; 4.22-4.23).

- * ***WE RECOMMEND that effective links are maintained or developed between learning disability, general psychiatric, forensic psychiatric and child and***

adolescent psychiatric services. There may be scope for joint consultant appointments covering more than one of these specialties.

Nursing

7.16. In 1990 there were 32,730 nursing staff working in hospital and community learning disability services. At 31 January 1992, over 180 were known to be working in "interim secure units" (see paragraph 4.16) for people with learning disabilities. There are reckoned to be no more than 50 community psychiatric nurses working full-time with mentally disordered offenders or with a specialist interest in such patients (ST 2.19).

7.17. The SHSA supplied detailed information (at May 1992) on registered nurses for the mentally handicapped (RNMH) working in Special Hospitals:

	RNMH only (total)	RNMH only (female staff)	RNMH and other qualification	RNMH and other (female)
ASHWORTH	131	29	44	7
BROADMOOR	-	-	-	-
RAMPTON	210	70	63	15

7.18. The staffing and training advisory group considered in detail the specialised training and education needed by staff working with mentally disordered offenders (ST 4.26-4.32). Relevant training elements for learning disability services should include recognition of social and educational needs, responses to the additional presence of mental illness, application of relevant legislation, the use of advocacy (*eg* in relation to provisions of the Police and Criminal Evidence Act 1984: see Annex M) and issues of violence and risk assessment. All RNMH students should have a secure unit placement. There is concern that the number of students on the new "Project 2000" courses opting for the mental health and learning disability specialties is declining and that, with the growth of community care, the ability of some nursing staff to deal with difficult or aggressive patients is declining (ST 4.33). The staffing and training group emphasised that training targets would need to be reviewed to meet the additional demands arising from this review (ST 4.27). The local interface between forensic psychiatric, general psychiatric and mental handicap nursing (the term is still used) must also be addressed (ST 4.25)

7.19. The report of a Chief Nursing Officers' working party, chaired by Professor Chris Cullen, on mental handicap nursing in the context of the community care White Paper, *Caring for People* (Cm 849, 1989), has been drawn to the attention of NHS managers: Executive Letter (91)114; PL/CNO(91)5. In his 1991 policy statement (see Annex C), Mr Dorrell said of this that "the continuing health service role...necessitates a long-term requirement for trained mental handicap nurses".

- * *WE RECOMMEND that, as part of the re-examination of training targets for nursing staff proposed by the staffing and training advisory group, health authorities consider the particular requirement for skilled nurses to work with offenders with learning disabilities and others requiring similar services. They should address also the ways in which forensic psychiatric, general psychiatric and mental handicap nursing relate to each other.*

Psychologists and therapists

7.20. The role of clinical psychologists, occupational therapists, speech and language therapists, and physiotherapists working with people with learning disabilities, and the need to balance the inputs of staff in different agencies, was described in the *Government's Response to the Social Services Committee* (1985) (*op cit*: see *Annex R*. Department of Health Circular (88)43 (see paragraph 3.6 above) and the draft 1991 health circular both emphasised the responsibility of health authorities to ensure the availability of these services.

Psychologists

7.21. The staffing and training advisory group commented on the general shortage of *clinical psychologists*, due mainly to the relative lack of postgraduate training (ST 4.37). There are about 110 NHS-qualified clinical psychologists working with offenders in England and Wales mostly in Special Hospitals and medium secure units (ST 2.23). Some work in Youth Treatment Centres (SN 4.17). There are also 133 psychologists employed by the prison service, only a small number of whom are qualified for NHS work (ST 2.52).

7.22. Many of these staff (although generally not those in medium secure units) will come into contact with people with learning disabilities. At 31 March 1989 there were about 330 whole time equivalent NHS clinical psychologists working with learning disabled people, about 17% of the national total (Manpower Advisory Group report). By 1992 numbers were estimated to be over 350.

7.23. *Educational psychologists* make an important contribution to the assessment of children and adolescents with learning difficulties, although there are wide variations of caseload between LEAs (Audit Commission/HMI, *op cit*, paragraph 28).

Therapists

7.24. In March 1989 there were 169.8 *occupational therapists* working in NHS community learning disability services in England and 252.3 working with learning disabled people in hospitals. Together they accounted for 9% of the total NHS OT workforce. In 1990 there were estimated to be 1,510 wte OTs employed by local authorities (*cf* 1,390 in

1988) (ST 2.26).

7.25. About half of the 2,850 *speech and language therapists* in England are reckoned to have had some experience of working with people with learning disabilities. There is a full-time speech therapist at each Special Hospital, plus a sessional post at Rampton (ST 2.29).

7.26. In 1990 there were 11,780 whole time equivalent NHS *physiotherapists* in the United Kingdom, of which about 600 were involved in the assessment and treatment of people with learning disabilities. All prisons, Special Hospitals and medium secure units have access to physiotherapy, but the staff concerned are not necessarily skilled in treating people with learning disabilities.

7.27. Other therapists (art, drama, etc) also make a valuable contribution.

7.28. The staffing and training advisory group regarded an expansion of therapy posts based in Special Hospitals and medium secure services (if necessary through more flexible purchasing mechanisms) as an early priority towards developing a more effective core service for mentally disordered offenders and similar patients (ST 3.47). We envisage that this would include a learning disability element to reflect the anticipated growth of specialised services for that group.

7.29. As with some NHS secure units, LEAs often find it difficult to secure paramedical services, especially speech and language therapy, specified in statements (Audit Commission/HMI, *op cit*, paragraph 111). While LEAs have a statutory responsibility to arrange such provision, this should normally be made by the NHS (*ibid*, paragraph 155; Addendum to DES Circular 22/89, paragraph 63(b)). DES guidance "encourages" education and health authorities "to cooperate closely in relation to the arrangements for the provision of speech therapy and allied services for children with special educational needs" (Addendum to 22/89, paragraph 63(c)). The Audit Commission/HMI have recommended that the responsibility of LEAs "as the providers of last resort should be recognised in the arrangements which are made nationally to fund speech therapy" (*op cit*, paragraph 155).

- * ***WE RECOMMEND that the development of a core therapy service for mentally disordered offenders, as proposed by the staffing and training advisory group, takes account of the needs of offenders with learning disabilities and others with similar needs.***

Social services

7.30. The staffing and training advisory group found no precise information on the number of social services staff working with mentally disordered offenders (ST 2.31) and recommended the collection of more comprehensive data (including, where appropriate those relating to general mental illness and learning disability services) (ST 2.37).

7.31. The following information for 1990 is available on the staffing of local authority places for people with learning disabilities (ST 2.36):

	PLACES	NUMBER OF STAFF
Residential homes/hostels	16,886	11,929
Adult training centres/special needs units	55,897	11,724

Staffing figures for the 7,894 places in voluntary homes and 8,882 in private homes are unavailable (ST 2.36).

7.32. At 31 January 1992 there were 3.6 whole time equivalent social workers identified as working with people with learning disabilities in "interim secure units". In July 1992 there were 30 social workers at Ashworth and Rampton Special Hospitals, though not all would necessarily work with mentally impaired patients. The Social Services Inspectorate will begin a national inspection of social work in Regional Secure Units and Special Hospitals in April 1993.

7.33. Better services for offenders should mean a small increase in the number of people with mild to moderate learning disabilities seen by social services. Social workers and residential, day care and domiciliary staff will have particular training needs, including for skills to encourage clients to manage socially and emotionally with the stresses of work and other aspects of daily life. Families and carers will require advice and support. There may be small additional inputs required to diversion schemes and other multi-agency mechanisms, although an estimate by the staffing and training advisory group for at least 125 additional social workers to work with mentally disordered offenders (ST 3.54-3.60), including 40-50 whole time equivalent for diversionary work, largely takes account of these.

Criminal justice services

7.34. The staffing and training advisory group considered the implications of the review for groups working within the criminal justice system, including the prison, police and probation services. Except perhaps in a few problematic cases, which may be resource-intensive for the agencies concerned, the needs of people with learning disabilities are unlikely to present significant additional resource implications for these services over and above those already identified by the staffing and training group for mentally disordered offender services generally (ST 3.62-3.68). However, allowance must be made for:

- i. *contact with learning disability services* (in addition to general and forensic mental health care services). The probation service, for example, have less experience and training in this area than in mental illness;

ii. *the need for a broad range of staff to be trained to recognise learning disabilities and to know how to respond* (see paragraph 2.8). There are particular risks in being unable to communicate effectively or on a suitable "level" with learning disabled suspects, including their appearing to assent to suggestions or accusations without full understanding (see, eg, Perske (1991) *Unequal Justice?*; Tameside Association for Community Living (1992) *Unequal Justice Conference Report*; Singhal, *Guilty until proven intelligent* (*Guardian*, 5 Aug 1992)). In addition, people with learning disabilities may be unable to follow court proceedings effectively (CR 2.27). The Court of Appeal recently ruled that where a prosecution case relies solely on a confession which is unconvincing and inconsistent, and the defendant suffers from a considerable degree of "mental handicap", the judge should take the initiative and withdraw the case from the jury (*R v McKenzie*, *Guardian law report*, 29 July 1992).

Chapter 8:

Research and academic development

Research

Report of the research advisory group (June 1992)

8.1. The research advisory group envisaged a more coordinated approach to the national commissioning of research on mentally disordered offenders (RS 2.1-2.8). It made no specific recommendations for research into offending by people with learning disabilities, although a number of the themes it identified (see matrix at *figure 3*) are of potential relevance. It attached the highest priority (RS 6.8) to:

- i. the identification of mentally disordered offenders at the arrest and court diversion stage, including the use of section 136 of the Mental Health Act (see paragraphs 4.9-4.11 above);
- ii. the treatment of, among others, people with psychopathic disorder and sex offenders;
- iii. treatment outcome measures;
- iv. ethnic minority issues.

Suggested priorities for learning disability research

8.2. The most recent study commissioned nationally on offenders with learning disabilities was that by Kiernan and Alborz (*op cit*) at the Hester Adrian Research Centre, Manchester (a unit which is core-funded by the Department of Health). This confirmed our view of the sparsity and diffusion of relevant information and suggested areas for further research:

- i. *secure provision for people with learning disabilities.* We agree that this needs to be examined, given the potential growth of medium and local secure services

Figure 3: Possible components of a strategic plan for research on mentally disordered offenders

TOPIC	SOCIAL POLICY	BASIC RESEARCH IN MEDICINE ETC	SERVICE DELIVERY	LEGAL AND PENAL PRACTICE
Mentally Disordered Offenders	Relationships between prevalence of offending by mentally disordered and social deprivation	Epidemiological surveys by NHS Region. Longitudinal studies of MDOs. Dev. of drug treatments.	Provision of services by general psychiatrists. Quality of aftercare in community.	Use of hospital/ guardianship/ probation orders or prison sentences
Personality Disorders	Environmental factors which influence personality disorder	*Literature review. *Treatability issues. *Diagnostic issues.	*Evaluation of treatment	Use of hospital/ prison disposals
Sexual Offenders		*Distinction between sexual disorders and sexual offending. Epidemiological survey in UK.	*Roles of penal health and social services	Effect of changes in law
Violent Offenders	Effect on victims	Relation to mental disorder. Treatment programmes in prison and community.	Evaluation of treatment programmes	
Police		Profiling offenders	*Services required to assist police to identify MDOs	*Use of section 136
Community Services		Effect of the reprovion of local services on mental health	*Effect of social supervision of restricted patients	
Prisoners		*Prevalence of mental disorder in remand prison population.	Arrangements for mental health services for prisoners	Measures to prevent suicide or self harm

TOPIC	SOCIAL POLICY	BASIC RESEARCH IN MEDICINE ETC	SERVICE DELIVERY	LEGAL AND PENAL PRACTICE
Adolescents	Effect of disturbed childhood on later incidence of mental disorder/offending	Indicators of future offending (especially sexual offending)	Evaluation of current inter-ventions (especially sexual offending)	Pathways into custody of juveniles (effects of new child and CJ legislation)
Diversion	Attitudes of prison officers to MDOs. Public attitude to not prosecuting mentally disordered.		*Resources required for effective diversion schemes	MHA sections - suitability of, for diverting MDOs from CJ system. Powers of judges/magistrates.
Hospital Services	*Outcome indicators for hospital care		*Assessment of needs for different types of hospital provision	
Women		Prevalence of mental disorder	Availability/use of services	Differential use of hospital orders
Ethnic Minorities		*Evaluation of treatment approaches and responses	*Availability/use of services. *Equitable treatment of Ethnic Minorities	

* Recommended priority (RS 6.8)

and the support for such research, *including on building design*, expressed to us by practitioners and planners;

ii. *a study of remand prisoners and those in police custody*. This too would be helpful if directed to the total remand population, thereby supplementing the work of Grounds (see paragraph 4.23-4.25) on people referred for a medical opinion;

iii. *children and young people who require secure provision or may do so if their behavioural needs are not met effectively*. We support very strongly this suggestion which relates to a relatively neglected area, involving young people who have often had a succession of placements. We draw attention also to the recommendation in our earlier report of a study to establish the national prevalence of children and adolescents generally requiring secure or related specialised services (SN 4.20);

iv. *a process study of offending and learning disabilities*. We see advantages in collating and disseminating examples of existing good practice and experience. This could also help to influence future policy and service development. *We should want to see particular emphasis given to the needs of people with mild learning disabilities* and the inclusion of services for people with autism (see paragraph 9.5).

8.3. We suggest two other areas for potential research:

i. *the competencies that staff require to manage offender and similar patients with learning disabilities*;

ii. *the needs of people with learning disabilities who commit sexual offences or arson* (see paragraph 6.14).

8.4. The Audit Commission/HMI have recommended research to identify how many children have emotional and behavioural disturbance, to discover what provision is currently made for them and to assess its effectiveness (*op cit*, paragraph 154).

Earlier studies

8.5. A number of earlier studies relevant to services for offenders with learning disabilities are listed at *Annex S*.

- * ***WE RECOMMEND that, having regard to the overall framework of research on services for mentally disordered offenders, priority for research on learning disabilities is given to the areas identified at paragraphs 8.2-8.3.***

Academic development

8.6. The report of the academic development advisory group concluded that the academic base for mentally disordered offender services was too small and needed to be expanded (AD 2.2). This should happen on a multi-disciplinary basis and with a wider geographical spread, though not at the expense of existing expertise (AD 3.1-3.7). The establishment of a department in the health care of prisoners was recommended (AD 7.7). It is important that future developments take account of both the need to underpin relevant services for offenders with learning disabilities and the existing contribution of centres that form part of the academic base for learning disabilities.

Chapter 9:

Autism

9.1. Autism is a comparatively rare condition, first described as such in 1943, whose main features are severe social impairment, communication difficulties, rigidity of thought processes and ritualistic patterns of behaviour.

Prevalence

9.2. Estimates of prevalence vary. There are maybe 3-5 people per 10,000 with typical (or "classic") autism, but autistic-like conditions are more common. The latter include a more able group of people with *Asperger's syndrome* (see Tatum (2nd ed 1991) *A Mind of One's Own*). The term, *pervasive developmental disorders*, as used in the World Health Organisation classification, refers to a group of autistic and autistic-like conditions. Estimates of prevalence for "pervasive developmental disorders" range from 13-22 per 10,000. Males outnumber females by about 4 to 1.

Government policy

9.3. Government policy on autism was set out in its *Response to the Social Services Committee* (1985, *op cit*):

Responsibility for policy on services for autistic people lies with the mental handicap branch [of the Department of Health]. Policy on autism requires development and is the subject of current consideration both within and outside the Department. Authorities should, in planning their services, bear in mind that autistic people may or may not exhibit features normally associated with mental handicap. A range of services will be needed to cater for individual needs and these should take account not only of the severity of features which are characteristic of autism (eg impaired communication, language, emotional or social functioning) but also the severity or absence of intellectual impairment and other features such as behavioural disturbance. Plans should include provision for regular in-service education and training for staff to provide basic knowledge... and build up relevant skills and techniques (*ibid*, Annex 2, paragraph 32(v)(b)).

9.4. *Needs and Responses (op cit)* looked briefly at services for autistic adults (NR 4.15-4.16).

9.5. The Department of Health and Department for Education have commissioned research on autism: Jones and Newson (1992) *Summary of a research project on the provision for children and adults with autism living in England and Wales*. A further evaluative study of interventions in six different settings is due for completion in April 1993. Jones and Newson did not address the specialised needs of offenders, except to the extent that their offending is incidental to service provision. They highlighted the needs of autistic people with "severely challenging behaviour" as a service issue for the future.

General aspects of service provision

9.6. For practical purposes, provision for autism and similar conditions is frequently included in learning disability services. However, although as many as 60% of people with autism might also be regarded as learning disabled (Ritvo *et al* (1989) *The UCLA - University of Utah Epidemiologic Survey of Autism: Prevalence*: abstract in *Excerpta Medica*, section 32, vol 59.9), they may not (as the Government guidance emphasises) exhibit features normally associated with learning disabilities. Some, such as those with Asperger's syndrome, may have marked verbal skills and highly developed special interests. Many become less disabled as they get older. However, as the following table illustrates, most people with autism are unlikely to become completely independent (Tantum, *op cit*):

SOCIAL ADJUSTMENT OF 46 ADULTS WITH AUTISM	
No contact with a friend in the last year	70%
No sexual relationship for more than a month	78%
Unemployed	85%
Never married	98%
Resident in hospital or with parents	76%

9.7. A range of specialised services is likely to be needed to cater for individual needs and to support parents and carers. This must take account not only of the severity of the behavioural features that are characteristic of autism, but also special medical needs (*eg* if the person has epilepsy), the potential for offending behaviour if particular activities or tendencies (sometimes seemingly innocuous) are not confronted, and the degree or absence of intellectual impairment. In particular, rather as the needs of people with mild learning disabilities may go unnoticed or unmet (see paragraphs 6.10-6.13), so autistic people of "normal" or borderline intelligence often receive little in the way of specialised services. Understanding of their needs is often limited or a diagnosis

may not be made (NR 5.4). Some may display characteristics which lead to their being diagnosed as schizophrenic; others may in fact have a dual diagnosis of autism and mental illness (Tantum, *op cit*). The assistance of staff with a particular knowledge and experience in this field may need to be sought in both assessment and case management. The National Autistic Society has issued a pamphlet on assessment and service needs (*Care services for people with autism*) to assist in the implementation of the NHS and Community Care Act: see *figure 4*.

9.8. A number of approaches to the care and education of autistic people are currently in use, reflecting some differing views about the nature of autism and its susceptibility to treatment. Generally these reflect an emphasis on firmness and a structured routine. Depending on the level of assessed need, there may be a scope for a specialised local service (as, *eg*, the health-based children's service described at *Annex 1*) or a resource centre (*eg* Ashton (1987) *Autistic Children: One Way Through*). There is a number of residential schools and centres run by voluntary autistic bodies.

9.9. 39 (of 108) LEAs have some specialised statutory or voluntary provision for autistic children. Among autistic adults, only 1 in 50 attend specialised facilities (Jones and Newson, *op cit*). There is little evidence of progress among health and social service authorities to develop services further (*ibid*), although, even if they were to do so, such developments would require sensitive planning. *Needs and Responses* warned of "the potential for isolation from other services and professional skills" (NR 4.16).

Offending

9.10. *Annex U* (Howlin, 1992) considers a number of aspects of offending by people with autism. There are no identifiable prevalence rates, but these are thought to be very low. Most offenders are probably among the minority of autistic people who are not also learning disabled, although some autistic behaviours may of themselves potentially bring people into the offending category.

9.11. Offending arises mainly from:

- i. deliberate exploitation by others;
- ii. aggressive behaviour, often resulting from disruption of routines;
- iii. anti-social behaviour occurring through lack of understanding or communication, obsessional tendencies, or morbid interests.

9.12. More needs to be done to raise awareness and understanding of the needs of autistic people and to develop responses to a range of offending:

In many cases the police have acted with considerable tact and understanding... frequently they do not press charges. However, there are cases when the behaviours are so dangerous, and when the individuals' perception of the implications of their actions is so poor, that confinement is necessary. Even in special prisons understanding of... autism is likely to be very limited and within the regular prison system there is likely to be no

figure 4

FACTORS TO BE CONSIDERED DURING ASSESSMENT OF PEOPLE WITH AUTISM

Autism is a perplexing life-long disability, believed to be caused by organic brain damage rather than emotional trauma. The spectrum of autistic conditions covers a wide range. It varies from profound severity in some through to subtle problems of understanding in others of apparently average or above average intelligence. Autism often occurs with other learning difficulties.

People with autism have a disability characterised by a triad of impairments as follows:

- absence or impairment of two-way social interaction
- absence or impairment of comprehension and the use of language and non-verbal communication
- absence or impairment of true flexible imaginative activity, with the substitution of a narrow range of repetitive, stereotyped pursuits.

This disability leads to related problems which may include:

- resistance to change
- obsessional or ritualistic behaviour
- high levels of anxiety
- lack of motivation
- inability to transfer skills from one setting to another
- vulnerability, and susceptibility to exploitation
- depression
- challenging behaviour
- self injury.

ADDITIONAL SPECIFICATIONS FOR THE PROVISION OF CARE SERVICES FOR PEOPLE WITH AUTISM

People with autism need and the service should provide:

- i) individualised and detailed IPPs (Individual Programme Plans)
- ii) detailed and specific strategies to achieve social interaction, communication and independence skills
- iii) highly planned structured activity
- iv) appropriate staff levels to implement the strategies and provide staff support in all areas
- v) an appropriate physical environment.

The service and the staff should provide:

- i) consistency and stability in the environment and in all interaction
- ii) continuous external motivation and positive intervention.

The service also needs to provide:

- i) a support system to handle and relieve staff stress
- ii) specialised staff training providing both an induction programme and an ongoing programme to reinforce and update the needed staff skills.

The staff role is crucial in enabling people with autism to participate more fully in everyday life.

Staff need a thorough understanding of the underlying impairment and to be attuned to the way the person with autism sees the world.

The staff training programmes should aim to provide:

- i) an ability to understand and interpret the verbal or non-verbal communications of the person with autism
- ii) an ability to translate situations, events and concepts, into language that can be understood and grasped by the person with autism
- iii) a sensitivity in the recognition of anxiety levels
- iv) skills in the management and reduction of challenging behaviour
- v) recognition of the value of repetitive reinforcement and the ability to make careful use of structure in order to counteract lack of motivation inherent in this disability.

knowledge of the nature of autism... In particular [autistic people's] apparent lack of remorse may result in unduly harsh treatment, especially when this is coupled with their marked impairments in social skills and their ability to form social relationships.

Adequate diagnostic and assessment services for people with autism, particularly those who are of normal IQ and whose deficits may be much more subtle than those shown by more severely handicapped individuals are essential... If offences do occur, the advice of special psychiatric or psychological services needs to be sought in determining both the risks of such behaviours occurring again and in advising about the most appropriate forms of treatment (*Howlin, op cit*).

9.13. The National Autistic Society* arranges awareness training and is able to advise generally on aspects of autism.

- * *WE RECOMMEND that agencies take account of the specialised and varying needs of offenders with autism, including the importance of links with other services that may be required.*
- * *WE RECOMMEND that agencies train their staff to recognise and, where possible, respond to the special challenges that autistic people present.*
- * *WE RECOMMEND research into the range of responses required to meet the needs of autistic people who offend or who have severe behavioural problems.*

* The National Autistic Society, 276 Willesden Lane, London NW2 5RB (telephone: 081 -451 5865).

REVIEW OF SERVICES FOR MENTALLY DISORDERED OFFENDERS

MEMBERSHIP OF THE OFFICIAL WORKING GROUP ON SERVICES FOR PEOPLE WITH SPECIAL NEEDS [from April 1992]

I N Dean (<i>Chairman</i>)	Grade 7, Health Care Division, Department of Health
A Backer-Holst	Nursing Officer, Department of Health
Dr D Brooksbank	Senior Medical Officer, Department of Health
Miss E D Cooper*	Grade 7, Health Care Division, Department of Health
Dr Diana Ernaelsteen	Senior Medical Officer, Department of Health/Senior Medical Adviser, Department for Education
J Greenland	Grade 7, Health Care Directorate, HM Prison Service
Mrs A S Holding	Social Services Inspector, Department of Health
Dr Dilys Jones	Senior Medical Officer, Department of Health
N J Jordan	Grade 7, C3 Division, Home Office
<i>Secretary:</i>	
Miss C F Cavanagh	Executive Officer, Health Care Division, Department of Health

** Secretary to the Mansell project group: see paragraphs 3.26-28*

REVIEW OF SERVICES FOR MENTALLY DISORDERED OFFENDERS

MEMBERSHIP OF THE STEERING COMMITTEE

Dr J L Reed (<i>Chairman</i>)	Senior Principal Medical Officer, Department of Health
R J Baxter (<i>Joint Secretary</i>)	Grade 5, C3 Division, Home Office
Professor R S Bluglass	Professor of Forensic Psychiatry, University of Birmingham
Miss E A Crowther	Director of Social Services, City of London
A J Davies	Director of Operations, Special Hospitals Service Authority
A H Fender	General Manager (Purchasing), Salisbury Health Authority
Professor J Gunn	Department of Forensic Psychiatry, Institute of Psychiatry
P R Herring	Director of Finance, St Helens and Knowsley Hospital Trust
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L R Joyce	Chief Executive, Newcastle Mental Health NHS Trust
Dr J O'Grady	Consultant Psychiatrist, Newcasatle General Hospital
T M O'Sullivan	Governor, HM Prison, Holloway
E Packer	Clerk to Wimbledon Magistrates
J Parry	Senior Nurse Manager, Scott Clinic, Rainhill Hospital

G W Smith CBE

HM Chief Inspector of Probation (lately
Chief Probation Officer, Inner London)

J G Smith

Assistant Chief Inspector,
Social Services Inspectorate

Chief Superintendant P
Stevens

Community Involvement and Crime
Prevention Branch, Metropolitan
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J Tait OBE

Deputy Chief Nursing Officer,
Department of Health

Dr Pamela J Taylor

Head of Medical Services,
Special Hospitals Service Authority

Dr Rosemary Wool

Director, Prison Medical Service

STEPHEN DORRELL'S MENCAP SPEECH/STATEMENT ON SERVICES
FOR PEOPLE WITH LEARNING DISABILITIES - TUESDAY 25 JUNE 1991

1. Sir Brian, members of the National Council of MENCAP, ladies and gentlemen, thank you very much indeed for inviting me to speak at your conference. The title of your conference is suggestive, to say the least, and it certainly is timely that at this time of major reform in the management of the NHS and major new initiatives in community care there should be a full and comprehensive restatement of Government policy. I thank you for providing me with the opportunity to make such a statement.

2. This brings me straight to the first point: Government policy in respect of whom? The name is important. It sends out signals; it has significant overtones and undertones. Without elevating the issue out of proportion, therefore, we have decided that the Department of Health will, in future speak of "people with learning disabilities" rather than of "the mentally handicapped". The priority we attach to the provision of comprehensive health and social care services for people disabled in this way will of course be unchanged, but I hope that the change of terminology will reflect a change of emphasis in the philosophy of care and in the values which inform our thinking. Most importantly, it should reflect our commitment to thinking of people with learning disabilities as individuals in their own right - people who are entitled to assistance in overcoming their disability for one simple

reason - they are citizens; they are full members of our society.

3. We believe that there are probably about 120,000 adults in England with a learning disability sufficiently severe for them to need significant help in order to live, and to have no prospect of being wholly independent. In addition there are of course very many thousands more people with a lesser degree of learning disability, whose needs must also be considered.
4. Much of what I have to say is also relevant to the needs of those with a lesser degree of disability but it is with 120,000 adults with a severe or profound learning disability that I am primarily concerned today. We intend to make a further statement later in the year about the needs of children with a learning disability, as part of a general statement on meeting the needs of children with disabilities.
5. Over the years since the 1971 White Paper "Better Services for the Mentally Handicapped", it has become increasingly recognised that the needs of most people with a learning disability, even those with a severe or profound disability, are largely for social care. During this time we have accumulated a lot of experience in developing home based, day and residential services that are more local, and often smaller in scale, and of resettling people from long term hospital care to community care. This experience has

confirmed that, with appropriate support and opportunities founded on the right values and service principles, people with learning disabilities are capable of considerable personal development and can make a positive contribution to society.

6. What do I mean by "right values and service principles"?

First, that people with a learning disability - of whatever degree - are entitled to be treated with the same respect and dignity as everyone else. They are people whose own views and wishes - as well as their relationships and friendships - must be taken seriously and respected at all times;

Second, and this flows very much from the first, that people with a learning disability should have their health and social care needs assessed on an individual basis, and not be offered predetermined sets of services because of ill-considered or outdated notions of what people with learning disabilities actually need or should be satisfied with;

Third, that people with learning disabilities have the same rights in relation to statutory services as anyone else. This includes the right of access to both primary and secondary health care as well as the right to have their needs for social care assessed. To secure this in reality means that any special difficulties they may have in enjoying equality of access and assessment must also be recognised and assessed.

7. During the last twenty years local authority social service departments have increasingly been seen as the main statutory agency for planning and arranging services, not only to people with a mild or moderate learning disability, but also to those with a severe or profound disability. The Government welcomes this development. As the changes resulting from the NHS and Community Care Act come into force, local authorities will have the clear statutory responsibility for assessing and as far as is practicable meeting the social care needs of people with a learning disability.
8. Once again let me define my terms. The phrase "social care" covers a wide range of support -
- : arranging accommodation and helping to make it into a home;
 - : providing personal support for daily living, in relation to basic activities of life such as eating, dressing and washing;
 - : assisting the development of friendships and social relationships;
 - : teaching and supporting socially competent behaviour;
 - : creating opportunities for the development of personal and social skills;

- : enabling the use of everyday community and leisure facilities;
- : helping develop occupational skills and finding and supporting employment;
- : facilitating access to health care and other statutory services and entitlements;
- : counselling to enable individuals with learning disabilities as well as their informal carers to make best use of available services;
- : providing social work help and support to enable individuals and families to deal with emotional and practical stresses.

9. To meet this diverse range of needs, local authorities will need to plan and arrange a wide range of home based, day and residential services, often by contracting them from the voluntary and private sectors. Even more importantly they will have to do so in ways that give people with learning disabilities and their families confidence in the continuity of support. Concern about the continuity of support is a major worry for many parents of people with learning disabilities, and lies at the root of concern about the closure of hospitals and the shift to what is perceived to be

less permanent forms of service provision.

The need, nevertheless, is to move away from a state of affairs where reliance and trust are placed primarily in facilities - in premises, buildings or institutions which are perceived as inherently trustworthy simply because they exist and are visibly permanent. We need to move away from this towards a system of care and support which can be trusted. A system which disabled individuals and their parents or carers can trust to respond flexibly and sensitively to needs and preferences which themselves may change significantly over time.

Our overall approach to Community Care was set out in the White Paper "Caring for People". The principles set out in that document must obviously guide our policy on the provision of social care for people with learning disabilities and we are today issuing a draft circular developing those ideas. That draft will now be the subject of a formal consultation with the local authority associations. It covers the whole range of services, but today I want to focus on two key areas - day services and residential services.

10. Day services are seen both by people with learning disabilities, and their families and carers, as vital. The provision of suitable day activities is the essential key to meeting many of the needs I referred to earlier. Over the past two decades there has been steady growth in provision.

In 1973 local authorities were providing 30,000 day centre places, whereas currently they provide about 56,000 places, an increase of 87%. For very many people with a learning disability, these day centre places represent a major element of service provision. Despite the growth, it has to be conceded that the availability of day services remains variable. Given their importance, we shall be looking to local authorities in preparing their Community Care Plans, to assess the needs of the populations they serve and, where provision is inadequate, to specify how they plan to improve the availability of day services for people with learning disabilities. Furthermore, we will be reviewing regularly with authorities their progress in implementing the planned improvements.

11. In 1989, the Social Services Inspectorate published the report of the first national inspection of local authority day services under the title "Individuals, Programmes and Plans". That report, with the ideas it suggested for the future development of services, was generally well received.
12. Today as an annex to the draft circular to which I have referred, we are publishing draft guidance on the development of day services, encouraging local authorities to shift away from services based on attendance at the traditional adult training centre, towards an approach to day services based on individual assessment. As resources allow, services should move towards a personally planned programme of day activities

- social, educational, vocational and leisure - delivered not in one centre, but making full use of ordinary community facilities. Day services provided in this way will often be coordinated from a local resource centre which will serve as the base for planning individual programmes and at which some services will be provided. But people with a learning disability must not rely solely on services which are provided solely for them; they must be helped to use local services such as the college of further education, employment services and leisure facilities, and this integration of their needs into normal local services will obviously require close cooperation between social service departments and other statutory agencies, particularly local education authorities. The development of a wide range of properly planned day services is particularly important for people leaving full time education, for whom the absence of such services can lead to unnecessary setbacks in personal development.

13. In planning day services, local authorities will need to work closely with those concerned to provide employment opportunities. In the past the view was widely held that people with a learning disability were incapable of holding down a job. We have learned from many schemes, including MENCAP's own Pathway Scheme, how mistaken a belief this was. It has now been shown that given appropriate training and support many people with learning disabilities can make use of the wide range of training and employment opportunities which exist.

14. Staff in the personal social services have a vital role to play in this respect. We look to them to cooperate with the employment services in developing employment opportunities. As well as training in the specific skills required for the work itself, people with learning disabilities may need help in developing the social skills necessary to hold down a job, for example in coping with money and public transport and in relating to fellow workers. They may also need help in finding a job which meets their particular needs and interests as well as support once they have started work. Others, who cannot cope with or do not want full time employment, may well be interested in including some form of employment experience in their day activity programme. I believe that there is enormous potential for people with learning disabilities to be helped to make a positive contribution to society in this way. I also believe that they will be helped to achieve greater social independence and self-assurance as they become more fully integrated into the community in which they live.
15. I now turn to residential care. Forty years ago, the norm for people with a severe or profound learning disability not living with their families was life in a large mental handicap hospital, often as one of a thousand or more patients. Over the years, staff, particularly mental handicap nurses, have done their best, often in very difficult circumstances, to provide a reasonable quality of life for people living in these hospitals. We have seen an indisputable improvement in

standards, and a very great deal of high quality care, which needs to be acknowledged.

16. But it also needs to be acknowledged that even people with severe or profound learning disabilities do not need to spend their lives in hospital simply by virtue of their disability. Local authorities must assess each individual's needs and, insofar as resources allow, plan a package of services aimed to ensure that the person with a learning disability receives the care which that person needs in the setting which offers most scope for the individual's development and well-being.
17. Some take the view that, where a person with a severe or profound learning disability does not live in the parental home, care should be provided on what is termed the "ordinary life" model. Here the preferred options include sharing a home with non-disabled people or living as part of a small group with chosen friends. Others seek a range of options, including sheltered housing, group homes, hostels and residential (including village) communities. The National Development Team's paper "Policies with Values and Vision for the 1990s" and the book "The Place of Special Villages and Residential Communities", edited by Professor Stanley Segal are good summaries of the pros and cons of particular options.
18. The need is to continue to emphasise that people with a learning disability should be treated as individuals, and cared for in circumstances where they are supported by people

who are respectful of them as individual human beings and who are able, in a continuing and stable relationship, to understand their needs and respond sensitively and flexibly to them. This means, in particular, reappraising what form of residential care may be appropriate and preferred by individuals at different stages in their lives. The ability to arrange an individually-centred service depends very much on the number, type, attitude and training of the staff providing residential care. Experience suggests that it may prove very difficult to achieve that kind of sensitive service in settings accommodating large numbers. Large institutions can have their own negative effects which are independent of the initial disabilities of those who are being cared for.

19. Authorities will need to consider what resources are available for residential care, and how these are best used to continue to make progress towards a service based around individuals. In the Government's view, there is a wide range of acceptable residential settings.

To be dogmatic about what is best simply by reference to a particular type of provision and to rule out other options would be an unwarranted presumption. Options include;

- living at home with one's parents;
- sharing accommodation with non-disabled people;
- living in an ordinary house, with or without staff support;
- for those who need rather more support, living in a staffed

hostel;

- residential homes provided by the voluntary or private sector;
- "core and cluster" accommodation where support is available from the core unit when needed;
- residential or village communities (provided they are outward looking and closely associated with the general community).

20. In many cases developing this range of options will involve major changes in present patterns of provision, and such changes cannot be brought about overnight. In these circumstances it is absolutely essential that the process of change should be planned and managed with the utmost sensitivity. In particular, a proper balance must be maintained between the ideal (in terms of range and variety of services) and the need to provide here and now an adequate level of services to meet current needs and reasonable present expectations. Having defined an objective there is always a natural impatience to achieve it now. However there will always be practical constraints and we must not let our enthusiasm for an ideal obscure the importance of improving provision for today's people with learning disabilities. The overall objective must be to create as wide a range of residential options as is practicable to meet the needs and wishes of those with a learning disability and at the same time to take fairly into account those of their families and carers.

21. When considering the extent and nature of long term residential accommodation to be provided, authorities should also consider the need for short term care accommodation. The Department estimates that more than half of all adults with severe or profound learning disabilities live with their parents or other informal carers. One of the services that is important to people with learning disabilities and which many parents and carers rely upon is short term care. We all - as individuals - occasionally need a break from each other, and that is as true of people with learning disabilities as of all the rest of us. Short term care can also assist in helping a person with a learning disability to make the transition from living with his or her family to living more independently away from the family home in chosen long-term residential accommodation, as well as offering extra opportunities to gain experience for people living in various kinds of long term residential accommodation.

22. At the same time short term care must be well organised. If it is not it can become a very distressing and damaging experience. Let me illustrate what I mean. A mother recently wrote to us recording her experience of short term care.

"I have just taken my eleven year old mentally handicapped son for one of his ten nights away in our local respite care facility. He will now spend twenty-four hours wondering why we have inflicted this on him.

He is with a totally random mixture of children, each of whom is "mentally handicapped". To my untrained eyes those children he was with tonight suffer many different afflictions, yet the "system" has to treat them all the same. This is not the fault of the very caring and competent staff - they are trapped by the economics of "care". For my son, who is very shy and quiet, he will now be forced to mix with some children whose behaviour is bizarre and frightening - to ME, let alone him!

Why should he need to have these very disturbing breaks to routine just so we can get a very short break?"

Why indeed?

23. I very much hope local authorities will remember that type of experience and look imaginatively at developing forms of short term care which are sensitive to the needs both of people with learning disabilities and their carers. We very much welcome, for example, the development of short term care through planned placements with "link" families, which has often proved both practicable and valued. Another important form of service is providing short term care in the person's own home, by arranging for someone to substitute for parents or carers whether just for one evening, or for a longer period. The need for an imaginative approach is no less simply because the timescale involved is shorter. Indeed the need to avoid unnecessary jolts may even require more imagination and

sensitivity. As ever - the key is to remember that what matters is the perspective of the individual disabled person.

24. Before I leave the area of social services departments responsibilities, I want to raise an issue about which I know many parents feel very strongly. In essence, it is the question of who is to decide what is best for an adult with a severe or profound learning disability? In many cases there is no disagreement about the package of care which should be available between the parents and the social services department or, insofar as his or her view can be ascertained, the disabled person. But in others there are disagreements, perhaps most often because of the tension between, on one hand, the need to protect a person with learning disability from danger or exploitation, and on the other the need to provide opportunities to develop independence.
25. There is no easy answer here. Disagreements between individuals, their carers and the local authority can be resolved at a local level, for example through the new complaints procedure. In the case of protecting individuals from danger and exploitation we move into an area which is currently under review by the Law Commission. We will be examining the complex issues involved as we consider the Law Commission's welcome consultation paper "Mentally Incapacitated Adults and Decision Making". I know that MENCAP and other bodies will be thinking hard about their response to that document and I hope that there can be thorough and

positive debate to inform any subsequent legislation.

26. I turn now to the responsibilities of the NHS for people with learning disabilities. There has been much concern that, with local authority social services departments becoming the main statutory agency for providing services for people with learning disabilities, the NHS would have no role. This would be a complete misunderstanding. We see the NHS having an important long term role, as well as what is best viewed as the transitional responsibility for the remaining specialist mental handicap hospitals.
27. In approaching the question of the NHS's long term responsibilities, the starting point should be the values and service principles I have mentioned earlier, in particular that people with learning disabilities have the same right to services as all other citizens, and should not be denied access to health care because of their disability.
28. Most people with learning disabilities are able to use the ordinary range of health services, although in some cases additional resources and help will be necessary to ensure firstly, that access to services is obtained and secondly, that after access is obtained the individual is supported and assisted in making use of the service. Others will have health care needs which can be only met by the provision of services specifically for people with learning disabilities.

29. This raises the question of who is responsible for ensuring that people with learning disabilities are able to gain access to the health care services they need and who should ensure that they are supported in using them. The answer is straightforward. This is a matter for health authorities. One of the merits of the NHS reforms which introduce the distinction between purchasers and providers is that such matters must be brought out into the open and addressed explicitly in NHS contracts. Health authorities are now under an explicit obligation to address the health needs of every individual resident within their district and that clearly includes those with learning disabilities. They must therefore ensure that their contracts make provision to meet the needs of people with learning disabilities in two ways:

- Firstly they must include in contracts for the ordinary range of services provisions for enabling people with learning disabilities to use the services in question;
- Secondly they will need to contract for additional services to meet those health needs of people with learning disabilities that cannot be met through the ordinary range of services;

30. What do I mean by "using ordinary services". First let me give some examples of problems that can arise:

- a hospital doctor is faced in his out-patient clinic with a person with severe learning disabilities who is without

speech;

- after an appendix operation, the nurses on a general surgical ward have to provide post operative care for a person with learning disabilities who does not seem to understand their requests, or conform to the ordinary ward requirements.

31. A little forethought can ensure that these problems are overcome:

- a person with knowledge and experience of people with learning disabilities could be available to facilitate the out-patient consultation, rather as an interpreter should be in cases of consultations between patients and doctors with no common language;
- the temporary availability of an experienced mental handicap nurse on the general surgical ward - or an early discharge with proper community nursing follow up - could avoid unnecessary disruption in the second example.

32. Neither of these examples, nor the many others that could be given, raises complex issues and not necessarily any requirement for more resources. The simple principle is that health authorities should ensure that people with learning disabilities are not excluded from treatment because of avoidable obstacles preventing access to services.

33. Furthermore, health authorities will also need to consider what arrangements are necessary to meet needs that are particular to people with learning disabilities. They will need to consider the following possibilities:

- First, alternatives to the ordinary services. In some places it may prove impossible for the general health needs of people with learning disabilities to be met by ordinary NHS services. For example, where local NHS dental practitioners feel unable to treat such patients, district health and family health services authorities will need to make alternative arrangements.
- Second, specialist mental health provision. Some people with learning disabilities need treatment for psychiatric illness or severe behaviour disturbance. If it is not possible adequately to meet these patients' needs within the general psychiatric services, specialist assessment and treatment services will be needed, in hospital or community settings;
- Third, NHS residential care. The large majority of people with learning disabilities not living with their families can be cared for in residential accommodation arranged through the relevant social services authority. There may, however, be a small number of people with severe or profound learning disabilities, and physical, sensory or psychiatric conditions who need long term residential care,

where a multi-professional assessment and consultation with parents or carers, leads to the conclusion that the services they need can only be effectively provided by the NHS. Similarly, where such people are ordinarily cared for by their families, there may be a need for some short term respite care arrangements to be provided by the NHS.

34. Health authorities will have to judge the pace at which progress can be made, in the light of the overall resource situation and other priorities. Through joint planning and work in developing community care plans, they must also consider the needs of local authority social services departments for health service professional input to assessment and service provision, and consider what resources it is realistic to make available.
35. In addition to seeking to meet the NHS's on-going responsibility for providing health services to people with learning disabilities, health authorities will also need to take account of the needs of patients in the remaining specialist mental handicap hospitals. There are currently some 25,000 people in such hospitals - over two thirds of whom have been there for at least five years. It is likely that most of these 25,000 people would now be assessed as inappropriately placed in what is, in effect essentially long term social care in an NHS residential setting, though some will also have chronic health needs in addition to their learning disability.

36. Some have suggested that the solution to this problem could be speeded up if it were possible, in appropriate cases, for NHS mental handicap hospitals to be transferred to the ownership of local social services departments together with their residents, staff and supporting revenue allocations. This would enable the social services department to take the lead in the development of the new community-based residential and day services with - of course - on-going interdisciplinary support from the NHS. As the alternative services were put in place, the social services department would organise the run down, and eventual closure and sale of the hospital premises. There are complex issues which would need to be resolved before any such transfer could take place, but if a particular health and local authority wished jointly to develop a specific proposal along these lines, we would certainly not put any obstacles in their way and we would do our best to facilitate the process.
37. In the absence of such a proposal, however, we look to health authorities to continue to work with matching social services departments in planning the transfer of residents, and resources to support them, to the community, with a view to closing the old mental handicap hospitals as quickly as practicable. The pace of transfer will inevitably depend on local circumstances and resources.
38. In the meantime, health authorities have a continuing

responsibility for the residents of mental handicap hospitals. While the hospitals remain there must be no abandonment of responsibility to maintain a satisfactory level of care. Indeed health authorities should aim to ensure that the quality of care these people receive improves at least in line with general improvements.

39. I now turn briefly to the important issues of staffing and training. The report of the UK CNO's working party chaired by Professor Cullen concerning the role of mental handicap nurses is to be published later this week. The continuing health service role I have set out clearly necessitates a long-term requirement for trained mental handicap nurses, and indeed for doctors specialising in the psychiatry of mental handicap and other professional staff who work with them. It is also likely that local authorities will wish to benefit from the skills of all these disciplines in planning, providing and purchasing social care.
40. As far as mental handicap nurses and other non-medical health service staff are concerned, manpower, planning and training matters now largely fall for consideration by regional health authorities, who will wish to involve social services departments before deciding on training levels. There are some complex issues about the ways in which the skills of mental handicap nurses should be made available to local authorities in connection with the development of the new pattern of services. The Department will be considering these

issues; our aim will be to try to ensure that there are no bureaucratic impediments to prevent local authorities benefiting from nurses' skills.

41. Doctors specialising in the psychiatry of mental handicap will also have a continuing and important role to play, both during the transitional period as services change from being hospital-based to community-based, and in the long term in the health service role which I have outlined. Regional Health Authorities should have a clear strategy, based on a realistic assessment of demand and the needs of provider units, to ensure that the requirements for trained medical staff are fully met.
42. I now come to the issue which I suspect causes health and social services authorities the greatest difficulty - responding to the needs of people with both learning disabilities and psychiatric or severe behaviour disturbance
43. Nearly two years ago, my Department published a document entitled "Needs and Responses", in order to stimulate local thinking about a set of issues for which there is plainly no simple or agreed service response. Since then we have worked with the British Institute of Mental Handicap, in holding a series of seminars to take discussion forward. Today the BIMH is publishing the fruits of those seminars under the title "Service Responses and People with Learning Difficulties and Challenging Behaviour", copies of which we are arranging to

be sent to all local authority social services departments, district health authorities and relevant NHS trusts.

44. I am also pleased to be able to announce today that, at the Department's invitation, Mr Peter Searle, Director General of the Mental Health Foundation, is to chair a small group, including people from services which have achieved some success in meeting the needs of people with learning disabilities and psychiatric or severe behaviour disturbance. The group's task is to identify the necessary elements of a successful service and produce much more specific guidance than is currently available. They will also keep in touch with the parallel review of services for mentally disordered offenders. I hope that the group's work will be available next year.
45. Finally, I come to the issue of resources. Since 1975, the story is one of steady progress. Taking health and social services expenditure together, there has been a real growth in expenditure on services for people with learning disabilities in every year to 1988/9, the latest for which figures are available. Over the period as a whole, the real growth has been over 16%.
46. As the economy picks up from the current temporary slowdown, I have no doubt that this trend of real, incremental growth will continue, as health and social services authorities benefit from economic growth. But it would be wholly wrong

to expect a "step change" increase in resources. Planning must proceed on a realistic basis, and that means thinking about the whole population of people with learning disabilities before authorities commit themselves to very expensive sets of services for small groups within that population. It also means being honest with people with learning disabilities, their families and their carers about what is, and is likely to become, available.

47. The record over the past twenty years isn't bad. Health and social services resources have grown in real terms and I am confident that as the Health Service and Community Care reforms are implemented, and with the stimulus provided by our new guidance, services for people with learning disabilities will continue to improve. The development of better services is a continuing priority and I hope that all concerned - people with learning disabilities themselves, their families and carers, the voluntary bodies, the private sector, health authorities, local authorities and my own Department - will accept it as their mission and will work together to plan, implement, develop and deliver services which are flexible, reliable and comprehensive - Better Services for People with Learning Disabilities.

DRAFT HEALTH CIRCULAR

HEALTH SERVICES FOR PEOPLE
WITH LEARNING DISABILITIES (MENTAL HANDICAP)

This circular will be cancelled [reviewed] on....

SUMMARY

People with learning disabilities (mental handicap) need, and have the same rights of access to NHS services as other citizens. They should not be hindered in gaining access to or denied health care because of their disabilities.

The enclosed Local Authority Circular "Social Care for Adults with Learning Disabilities (Mental Handicap)" and the annexed booklet "Developing Day Services for People with Learning Disabilities (Mental Handicap)", reinforce general advice to local authorities on developing community care and give specific guidance on the planning of services. This Circular asks NHS purchasing authorities to include in their contracts specific provisions to enable people with learning disabilities to access and use NHS health care services and, where necessary, to make special provision in cases where the health care needs of people with learning disabilities cannot be met through the ordinary range of services.

ACTION

1. District health authorities should:

- (a) ensure that service specifications for health care include appropriate provision for meeting the needs of people with learning disabilities, and should use contracts with provider units to ensure that wherever practicable people with learning disabilities are enabled to use the ordinary range of health services;
- (b) consider contracting for additional services for people with learning disabilities, including:
 - alternatives to the ordinary services, where it proves impossible for their general health needs to be met by ordinary NHS services;
 - specialist assessment and treatment services, in hospital or community settings, where patients with learning disabilities need treatment for psychiatric illness or severe behaviour disturbance that can not be met adequately within the general psychiatric services; and
 - residential care (or respite care) for people with severe or profound learning disabilities and physical, sensory or psychiatric conditions, where a multi-professional assessment and consultation with parents or

carers leads to the conclusion that only the NHS can provide the services they need cost effectively.

- (c) aim to ensure that during the transition to community-based services, the quality of care provided in specialist mental handicap hospitals improves at least in line with general improvements in health provision.

BACKGROUND

2. People with learning disabilities (mental handicap) have the same rights of access to health services as all other citizens. Many have greater health needs than people without such disabilities; this makes it all the more important that they should not be denied access to health care because of their disabilities.

3. Most people with learning disabilities need, and can use, the ordinary range of health services. Some, however, will need assistance or special consideration if they are to be able to use these services. Others may have needs that can only be met by the provision of services solely for people with learning disabilities.

NHS RESPONSIBILITIES

Contracts for the ordinary range of health services

4. Examples of common situations that can make it difficult for people with learning disabilities to get the health care they need, or be treated satisfactorily, are set out in the annex to this note. Sometimes these difficulties can be overcome without additional

resources, in other cases additional resources will be necessary to enable people with learning disabilities to use the services satisfactorily. Either way, purchasers should aim to ensure that, wherever practicable, people with learning disabilities can use the ordinary range of health services.

Contracts for additional health services

5. Purchasers will also need to consider contracting for services to meet the health needs of people with learning disabilities that cannot be met through contracts for the ordinary range of services. Consideration should be given to the following possibilities:

- alternatives to the ordinary services

In some places it may prove impossible for the general health needs of people with learning disabilities to be met by ordinary NHS services. For example, where local NHS dental practitioners feel unable to treat patients with severe learning disabilities, district health and family health services authorities will need to arrange alternative services as per circular HC(89)2;

- Specialist mental health provision

Some people with learning disabilities need treatment for psychiatric illness or severe behaviour disturbance. If it is not possible adequately to meet these patients' needs within the general psychiatric services, specialist assessment and treatment services will be needed, in hospital or community settings;

- NHS residential care

The large majority of people with learning disabilities not living with their families can be cared for in residential accommodation arranged through the relevant social services authority. There are, however, likely to be a small number of people with severe or profound learning disabilities and physical, sensory or psychiatric conditions who need long term residential care, where a multi-professional assessment and consultation with parents or carers leads to the conclusion that the services they need can only be appropriately and cost effectively provided by the NHS. Similarly, where such people are ordinarily cared for by their families, there may be a need for some short term respite care arrangements to be provided by the NHS.

Transitional responsibility for people in mental handicap hospital

6. In addition to seeking to meet the NHS's on-going responsibility, for providing health services to people with learning disabilities, district health authority purchasers will need to take account of the needs of the residents of the remaining specialist mental handicap hospitals. There are currently some 25,000 people in such hospitals - over two thirds have been there for at least five years. It is likely that most of these 25,000 people would now be assessed as inappropriately placed in what is, in effect, essentially long term social care in an NHS residential setting, though some will also have chronic health needs in addition to their learning disability.

7. Steady progress is being made with the relocation of such residents into community settings. Ministers look to health

authorities to continue to work with matching social services departments in planning the transfer of residents, and resources to support them, to the community, with a view to closing the old mental handicap hospitals as quickly as practicable. The pace of transfer will depend on local circumstances and resources.

8. In the meantime, district health authorities have a continuing responsibility for the residents of mental handicap hospitals. While the hospitals remain there must be no abandonment of responsibility to maintain a satisfactory level of care. Indeed health authorities should aim to ensure that the quality of care these people receive improves at least in line with general improvements.

NHS RESPONSIBILITIES TO LOCAL AUTHORITIES

9. Local authorities will look to health authorities to secure through their contracts the services of professional staff, including nurses, psychologists and therapists, to assess the needs of individuals with learning disabilities and to provide health services for them.

Enquiries

Any enquiries about this HC should be addressed to:

[]

ANNEX

USING ORDINARY SERVICES

1. The following are examples of problems that can arise which may either prevent people with learning disabilities from getting the health care they need, or make their experience of receiving health care much less satisfactory than that of a person without a learning disability:

- a hospital doctor is faced in his out-patient clinic with a person with a severe learning disability who has no speech;
- after an appendectomy, the nurses on a general surgical ward have to provide post operative care for a person with a learning disability who does not seem to understand their requests, or conform to the ordinary ward requirements.

2. With forethought problems such as these can be overcome:

- a person with appropriate knowledge and experience of people with learning disabilities could be available to facilitate the out-patient consultation, rather as an interpreter is necessary in cases of consultations between patients and doctors with no common language;
- either the staff of the general surgical ward could be augmented with the temporary help of experienced mental handicap nurses, or early discharge could be arranged, with proper community nursing provided.

3. Neither of these, or many similar examples that could be given, raises complex issues, but some prior consideration is needed if people with learning disabilities are to be enabled to use the ordinary range of health services and be satisfactorily treated while doing so.

DRAFT LOCAL AUTHORITY CIRCULAR

SOCIAL CARE FOR ADULTS WITH
LEARNING DISABILITIES (MENTAL HANDICAP)

SUMMARY

This circular gives specific guidance to local authorities on planning services for adults with a learning disabilities (mental handicap). It reinforces the general guidance on developing community care set out in "Community Care - the Next Decade and Beyond". Separate guidance will be issued later in relation to services for children.

ACTION

Local authorities are asked to take account of the guidance in this circular when preparing their community care plans and purchasing specifications, and when designing and developing care management and quality assurance arrangements for adults with a learning disability.

CONTEXT

1. Over the years since the 1971 White Paper "Better Services for the Mentally Handicapped", considerable experience has been developed in providing new forms of home care, day and residential services for people with learning disabilities (mental handicap). There has also been increasing experience of managing the transition from one form of

service to another (especially resettling people from long term hospital care to locally based, smaller scale forms of care). This experience has confirmed that, with appropriate support and opportunities, people with learning disabilities are capable of considerable personal development and of making a positive contribution to society, and few, if any, need to live long term in hospitals.

2. Over the last twenty years, local authority social services departments have increasingly been seen as the main statutory agency for planning and arranging services, not only for people with a mild or moderate learning disability, but also for those with a severe or profound disability. The Government believes this trend is right, and as the changes resulting from the Health Services and Community Care Act come into force, local authorities will have the clear statutory responsibility for assessing, and where practicable, making arrangements for meeting, the social needs of people with a learning disability, and for bringing apparent housing and health care needs to the attention of the appropriate authorities through their community care plans. There is also a clear need to plan services in close collaboration with local education authorities.

POPULATION TO BE SERVED

3. There is no precise information available nationally about the number of people with learning disabilities, or the degree of those disabilities. Evidence from a number of epidemiological studies

suggests there are probably around 120,000 adults in England with severe and profound learning disability, most of whom require considerable help in order to live, initially in their family homes and later in appropriate residential accommodation. This number may be growing, as advances in treatment mean people with particular forms of disability have a greater life expectancy. In addition, there are probably about 30,000 children under 16 with severe or profound learning disabilities whose needs and wishes, and those of their parents, as they approach the transition to adulthood, need to be determined and taken into account. Finally, there are many thousand of people with a mild or moderate degree of learning disability, whose needs for support vary widely, but must also be considered.

4. Of the approximately 120,000 adults in England with a severe or profound learning disability, the Department estimates that, currently, about a quarter live in hospital and NHS community units, up to another quarter live in residential accommodation provided by local authority social services departments or the voluntary or private sectors, and at least half live with their parents or other carers.

SERVICE PRINCIPLES

5. Policy for providing services, and services themselves, should be based on clear principles founded on explicit values. Authorities should be guided by the general approach to community care set out in the White Paper "Caring for People" (Cm 849) and the subsequent policy

guidance "Community Care in the Next Decade and Beyond", and by the guidance more specific to the needs of people with learning disabilities set out in paragraphs 6-8 below.

Services should be planned on an individual basis.

6. In the past people with learning disabilities have often not been treated as individuals, with very personal needs and preferences, but rather offered pre-determined sets of services (and denied others) on the basis of stereotypical notions of what people with learning difficulties need. The individuality of people with learning disabilities should be recognised and the aim in future should be to arrange services on an increasingly individual basis, taking account of age, needs, degree of disability, personal preferences of the individual and his or parents or carers, culture, race and gender.

The contribution of parents and carers, and resolving conflicts

7. Parents and carers usually have unmatched experience of the individual disabled person and his/her needs and preferences, and they should be fully involved in decisions about the services to be arranged. Sometimes there will be differences of view between people with learning disabilities and their parents/carers over what services are most appropriate. Conciliation and counselling should be offered in such situations, but in general the views of the person with a learning disability should be respected. There may also be differences of view between parents and professional staff. Every

effort should be made to resolve these. Where this cannot be done it is open to the parent to involve the complaints procedure and seek a formal view.

Continuity of service provision.

8. Many people with severe or profound learning disabilities will need support throughout their lives, though the nature of that support needs regular appraisal so that changing circumstances and needs can be identified. Parents and carers are often understandably anxious about the continuity of service provision, particularly continuity of caring and service provision after their own deaths. Some parents and carers are concerned about the closure of the traditional mental handicap hospitals precisely because such hospitals seem to offer more assurance about continuity of caring and support than community based services. Authorities should recognise these entirely legitimate concerns and aim to give assurance that the essential needs of severely and profoundly disabled people will be met on a life-long basis.

PLANNING TO MEET SOCIAL CARE NEEDS

9. The purchase and provision of social care should be seen as an active and responsive process that builds where possible on the expressed wishes and preferences of individuals, recognising their strengths and aiming to meet their needs. Skills in those care management issues specific to people with learning disabilities will

need to be developed. Social care refers essentially to the person to person support that may be needed in any or all of the following:

- : arranging accommodation and helping to make it into a home;
- : providing personal support for daily living, in relation to basic activities of life such as eating, dressing and washing;
- : assisting the development of friendships and social relationships;
- : teaching and supporting socially competent behaviour;
- : creating opportunities for the development of personal and social skills, and enhancing and maintaining competencies.
- : enabling the use of everyday education, leisure and other facilities in the community;
- : helping develop occupational skills, and finding and supporting employment;
- : facilitating access to health care and other statutory services and entitlements;

- : counselling to enable the individual with learning disability or his family/carers to make best use of available services.
- : providing social work help and support to enable individuals and families to deal with emotional and practical stresses.

10. To meet this diverse range of needs, local authorities will need to adopt a co-ordinated approach, involving all relevant departments, professional inputs, including those of NHS staff, to plan and arrange a wide range of services, where appropriate by contracting them from the voluntary and private sectors. Services should be developed in accordance with the principles referred to in paragraphs 5-8. The following paragraphs and the annex offer specific guidance on planning and assessing home care, day and residential services.

HOME CARE AND SUPPORT SERVICES

11. Home care and support services have four main elements:
- (i) providing reliable help with direct, physical and personal care, and day to day living activities;
 - (ii) teaching skills in their own or family homes to increase the independence of people with learning disabilities. It will also be necessary to extend this teaching into people's

places of work, learning or daily occupation, on public transport and in various community settings;

- (iii) offering 'sitting services' on a routine basis, in and out of office hours and at times of stress and pressing need;
- (iv) providing information about services and benefits available to people with learning disabilities and their families or carers.

DAY SERVICES

12. Day services are seen both by people with learning disabilities, and their families and carers, as providing vital opportunities for personal development. The provision of suitable day activities is an essential component in social care as outlined in paragraph 9 above.

13. Traditionally local authorities have sought to create day opportunities largely through the provision of adult training centres. They currently provide about 56,000 day centre places, and for very many people with a learning disability, these represent a major element of service provision. Inevitably therefore, such centres have come to be viewed as having a key role.

14. In 1989, the Social Services Inspectorate published the report of the first national inspection of local authority day services under

the title "Individuals, Programmes and Plans"¹. That report, with the ideas it suggested for the future development of services, was generally well received, and forms the basis for the following guidance.

15. Local authorities should plan to shift away from services based on attendance at the traditional adult training centre, towards an approach to day services based on individual assessment and programmes, in which skill learning and vocational preparation are prominent. The aim should be to move towards a personally planned programme of day activities - social, educational, vocational and leisure - which make use of ordinary community facilities wherever practicable.

16. It is of particular importance that day opportunities should enable the gains of people's school years to continue to be maintained, and where practicable enable them to achieve even greater independence. They should be planned to build on the programmes that have been provided by local education authorities during the school years, to try to meet the more hopeful expectations of people's families and advocates.

17. In some areas, local authorities are moving towards a "resource centre" approach, in which the centre serves as the base for the planning of individual programmes and the provision of some services.

¹ available from Department of Health Publications Unit, Site No 2, Manchester Road, Heywood, Lancs, OT10 2DL

People with learning disabilities are also supported in using the education, training and employment opportunities in the locality available to the community as a whole.

18. As part of the development of new forms of service, local authorities should give particular priority to provision for people with learning disabilities and special needs.

19. In planning day services, social services departments will need to work closely with education departments, particularly in relation to making provision for those leaving full time education as required by the provisions of the Disabled Persons (Services, Consultation and Representation) Act 1986, with health authorities, and with those concerned to provide employment opportunities.

20. Given the necessary training and support many including those previously not thought capable of employment are able to work. Authorities should seek to make full use of the wide range of training and employment opportunities which now exist for people with learning disabilities including sheltered workshops, supported employment, schemes and open employment in a variety of jobs and industries.

21. Annexed to this circular is a booklet of more detailed guidance on the development of day services, which focuses upon the main issues discussed in the 1989 SSI report. Authorities should use this guidance to develop new forms of day services, so that over time existing services are developed and brought into line with the pattern

of services recommended.

RESIDENTIAL CARE

22. Most adults with severe or profound learning disabilities are likely to need to live other than in their family homes at some point. In considering residential needs local authorities will need regularly to assess each individual and the capacity and willingness of families and carers to continue to support the individual and, insofar as resources allow, plan a package of services aimed to ensure that he or she receives any supporting services needed in the setting which offers most scope for individual development and well-being.

23. Some take the view that, where a person with a severe or profound learning disability does not live in the parental home, the selection of housing and support should be guided by the "ordinary life" model. Here the preferred options include living alone in a flat or house, sharing a home with non-disabled people, living with partners or as part of a small group with chosen friends. Others seek a range of options, including sheltered housing, group homes, hostels and residential (including village) communities. Contrasting views on the pros and cons of particular options are set out in the National Development Team's paper "Policies with Values and Vision for the 1990s"² and the book "The Place of Special Villages and Residential

² Available from the National Development Team, Ray House, 6 St Andrew Street, London EC41 3AD

Communities", (Segal, 1990)³.

24. The need is to continue to move towards arrangements in which people with learning disability are increasingly treated as individuals, in circumstances where they are supported by people respectful of them as individual human beings and able, in a continuing and stable relationship, to understand their needs and respond sensitively and flexibly. This means, in particular, reappraising the form of housing and support preferred by individuals at different stages in their lives. The ability to arrange an appropriate, individually-based service depends largely, though not exclusively, on the number, type, attitude and training of the staff providing support. This may prove very difficult to achieve in settings accommodating large numbers, as large institutions can have their own, negative effects which are independent of the initial disabilities of those being cared for.

25. Authorities will need to consider what resources are available for developing services, and how these are best used to continue to make progress towards a service based around individuals. In the Government's view, there is a wide range of acceptable living arrangements, including sharing with non disabled people, ordinary housing, hostels, homes and (provided they are outward looking and closely associated with the general community) residential or village communities. The key issue to be faced locally is what housing and

³ Published by AS Academic Publishers, PO Box 42, Bicester, Oxon OX6 7BW (ISBN 0-907360-16-5)

support services can provide greatest scope in moving towards an increasingly individually-based service able to meet the needs of people as outlined in paragraph 9, while being realistic in terms of resources.

26. Short term care. When considering the extent and nature of long term housing arrangements to be provided, authorities should also consider the need for short term care accommodation. The Department estimates that more than half of all adults with severe or profound learning disabilities live with their parents or other informal carers. One of the services that is important to people with learning disabilities and upon which many parents and carers rely is short term care, to give them a break from caring when family circumstances require it. Short term care can also assist in helping a person with a learning disability make the transition from life with his or her family to living more independently. Finally, short term care can offer extra opportunities and experience for people with learning disabilities living in various kinds of long term residential accommodation.

27. Authorities should look imaginatively at developing forms of short term care sensitive to the needs both of people with learning disabilities and their carers. In particular the development of short term care through planned short term placements with "link" families, has often proved both practicable and valued, and should be considered. Another important form of service is providing short term care in the person's own home, by arranging for someone to substitute

for parents or carers, whether for an evening or for a longer period.

RESOURCES

28. Services for people with learning disabilities provided or arranged by local authority social services departments have increased substantially. Nationally, since 1979 identifiable expenditure on such services has increased every year in real terms, and the Government expects that this will continue. The pace at which services can develop in particular localities is, however, a matter for local determination in the light of available resources and competing pressures on service. While setting out the desirable direction for future service developments, this circular places no specific new requirements on local authorities.

DHSS CIRCULAR HSC (1S) 161 (JULY 1974)

SECURITY IN NHS HOSPITALS FOR THE MENTALLY ILL AND THE
MENTALLY HANDICAPPED

Summary

This Circular gives guidance to health authorities on services for those mentally ill and mentally handicapped patients who, although not having the dangerous or violent propensities which would require their admission into a Special Hospital, cannot satisfactorily be managed in the ordinary wards of psychiatric hospitals.

1. In recent years there has been a growing problem in a number of regions as more hospitals have become entirely open-door and have often not made provision in accordance with HM(61)69 for the continuously difficult, behaviourally disturbed patients who were formerly contained, albeit sometimes unsatisfactorily, in locked wards. One consequence has been greater pressure on the Special Hospitals which are already overcrowded; they, in any case, provide a degree of security greater than is required for these groups of patients. The Department does not wish to see a reversal of the trend towards more open care and treatment of the great majority of patients in hospitals for the mentally ill and the mentally handicapped. However, it will continue to be necessary for places to be available in each region for patients requiring treatment in varying degrees of security short of that provided by the Special Hospitals. The most urgent need is for the establishment of Regional Security Units for the most difficult group of these patients and for arrangements to be made in the interim before the Units are ready to receive them. This circular gives guidance on these aspects of the security arrangements.

2. Enclosed is a copy of the Revised Report of a Departmental Working Party which has been looking into this question. The Working Party's first report was circulated to professional and other bodies and associations in August 1973 and has been revised by the Working Party in the light of comments received. The Department commends the report to health authorities and endorses its recommendations for the setting up of regional security units.

Interim Report of the Committee on Mentally Abnormal Offenders

3. Enclosed also is a copy of an Interim Report by the Butler Committee on Mentally Abnormal Offenders which has been submitted to Ministers in this Department and in the Home Office; the Report urges that immediate action should be taken to establish 2,000 places in regional secure units (paragraph 13) and that a direct allocation of Central Government funds should be made for this purpose (paragraph 21).

Planning of Regional Security Units

4. The Secretary of State attaches great importance to the early establishment of Regional Security Units and hopes that Regional Health Authorities will take urgent action to this end. In order to facilitate this, the Department will, after the agreement of proposals, make a direct supplementary financial allocation to regions for this purpose. Since both speed and economy are important, authorities should consider whether the adaptation of suitable existing premises would be possible. Initially the aim will be to provide 1,000 places, to be followed by an increase to the figure recommended by the Butler Committee if the need is confirmed by experience, as and when resources permit.

5. The Secretary of State expects a substantial number of Regional Health Authorities to begin work on the planning and construction of secure regional units (by adaptation or new building) in 1975/6 and that all RHAs should have started construction or adaptation by 1976/7. The Department, through its Regional Group, will agree with individual RHAs the way in which this objective is to be achieved and the allocation to be provided, as part of the process of agreeing regional plans and budgets.

Interim arrangements for the period before units come into operation

5. In the interim before regional secure units can be provided, it is essential for places to be made available for each region for patients requiring treatment in conditions of security short of that provided by the Special Hospitals. All Regional Health Authorities should therefore in conjunction with Area Health Authorities make interim arrangements to designate particular hospitals to provide treatment in conditions of security until such time as proper regional secure units can be provided.

7. The regional group will, after discussions with Regional Health Authorities, indicate the date by which the Secretary of State should be notified of the interim arrangements proposed for each region.

Training arrangements for staff of Regional Security Units

8. Guidance will be issued in due course.

Extract from "Needs and Responses" (Department of Health, 1989)

CHAPTER 7

SUMMARY

Planning

7.1 Co-ordinated, multiagency planning is essential in order to provide a comprehensive and integrated special service for those with special needs, in addition to the general services provided for adults with mental handicap. These plans need to include prevention and early intervention. The special services will need to be monitored and evaluated to ensure that they meet the individual needs identified by a thorough assessment of each person. The services need to be flexible to accommodate changes in behaviour or to introduce new, effective treatments. There should be easy access to all specialised services.

7.2 Managers and planners will need to seriously consider the views of the consumers and service providers prior to finalising plans and during the monitoring process.

7.3 Care has to be taken to identify and update the needs of all those requiring specialist health care services. This may be difficult but is essential. Data will need regular updating. Planning for special services should include amongst other specialist groups, the number of people with severe behaviour disturbance, and the number of treatment places required for those who are mentally ill or who offend and, lead to policy statement and action plans in accordance with HC(88)43.

7.4 The aim should be to provide services locally to maintain the individual's social links. However, some services may be so specialised that they will need to be developed on a supra-district or regional basis. For example, some people will require secure accommodation, but less than that provided by a special hospital. As so few people fall into this group, planners and managers may feel it may be cost-effective to use the services in the private sector. In this event the District must remain involved to ensure effective treatment programmes are instituted, and to participate in the transition and return to local services.

7.5 Once the overall service has been planned, all participating agencies need to be kept fully informed. This may be best achieved by setting out the agreed strategy plans and targets which includes provision for quality assurance. This will need wide dissemination and to be brought to the attention of all staff, especially those directing and providing services to clients.

Identification and Assessment of Need

7.6 A holistic approach to identification and assessment is important. Early multi-disciplinary assessment of needs requiring further specialist assessment should be made, in the person's usual living environment, resulting in the formation of a plan of management. The family's involvement in this process is essential.

7.7 Assessment is a continuous process. Reviews of needs are an integral part of the Individual Programme Plan, which should address remedial action for any physical or mental illness. Assessment must be systematic and recorded and must identify needs irrespective of available services.

7.8 Experience gained from individual assessment should inform the planning process.

7.9 Some people will have intractable problems requiring long-term care, and their needs must be regularly reviewed to ensure the highest quality of care possible.

Adults with Mental Handicap who are Mentally Ill

7.10 Those with mental illness are the largest group of people with mental handicap who have special needs in regards to behaviour. Whatever the cause life - stresses are significant. Prevention of stress reactions depends on planned, sensitive and supported placements.

7.11 Primary health care services are often the first to be involved and may manage the minor psychiatric disorders themselves. All people with mental handicap in the community should be registered with a G.P. and GPs may need to be given additional training to help them deal with patients with mental handicap.

7.12 The person with mental illness should not pass from one service to another because of diagnostic or management difficulties. Diagnosis is important to distinguish mental illness from other forms of behaviour disturbance, although they may co-exist.

7.13 Thought needs to be given to the most appropriate services and settings to manage and treat these conditions, many of which can be treated on an out-patient or day-patient basis. Three models of inpatient care are outlined, with their advantages and disadvantages. Treatment and rehabilitation will take longer, especially for those with severe mental handicap.

7.14 Whatever service is chosen it is likely to be costly, and some people with very special needs may require exceptional placement, at great cost. Joint-funding will be all the more important. Research indicates that the shift from hospital to the community of people with mental handicap is likely to be more costly than for people with mental illness, possibly because they tend to be more disabled and that voluntary sector residential facilities appear to be more cost-effective than local authority or NHS facilities.

Adults with Mental Handicap who are Behaviourally Disturbed

7.15 Assessment, including psychiatric assessment, is needed to identify any additional problems such as sensory impairment (more common than had been realised), brain pathology, chromosomal abnormalities and major sociocultural factors.

7.16 Those previously unknown to services need to be identified and steps taken to prevent this happening in the future, so that early intervention can occur and the person will not be left in isolation.

7.17 The person with mental handicap who is autistic and the person with mental handicap who is behaviourally disturbed may have an overlap of needs, but the severe social and communication problems of the autistic group need to be addressed when planning services.

7.18 Whatever intervention is chosen for behaviourally disordered people, and in whatever setting, there is a need for privacy, physical and personal space, and a variety of activities and environmental stimulation, including general recreation and sport. Maintaining links with relatives and the general community is very important. Authorities should jointly plan for this.

7.19 Management should supply all staff with a clear, written operational policy. Staff need on-going training and on-going support from managers and specialists. High staffing levels will be inevitable and their deployment needs to be flexible and sensitive to cope with crises. All this will mean extra costs.

7.20 Accommodation may be provided by the upgrading of existing buildings if they are small enough to meet modern philosophies of good care; or by the purchase of suitable houses or the erection of purpose-built facilities. These people may be placed together, on their own, in ordinary families or with ordinary people with mental handicap. The major choice is between ordinary housing or specialist units, although both may be provided. Research suggests that community care for those people previously in hospital is likely to cause an increase in behaviour problems, although an increase in skills and abilities is also likely to occur.

7.21 Wherever a person is placed, easy access to specialist services is essential. Consultants in the Psychiatry of Mental Handicap must respond when requested, and continue to provide a psychiatric input for difficult cases when placement is being planned, even if psychiatrists from other specialties are involved.

Adults with Mental Handicap who Offend

7.22 Services for this small but very special group must be planned in a systematic way.

7.23 The best service will emphasise prevention since this can reduce the impact of offending behaviour on the individuals, their carers and on society.

7.24 The usual services will be required but additional special services must be provided to meet identified needs. The network of community services will need to liaise with the police, courts, prisons, probation, mental illness and forensic psychiatry services, local authorities and other relevant organizations involved with offenders.

7.25 Secure provision is one major issue to consider. All levels of security, less than that provided by Special Hospital, need to be available. Inappropriate applications for admission to Special Hospital result from a failure to provide the appropriate facilities locally.

7.26 There must be access to special inpatient units, which are likely to be sub-regional or regional, for evaluation and treatment, both short-term and long-term. Whatever placement is found there must be adequate, continuous, planned aftercare facilities, including long-term care for those who need it.

7.27 The staff caring for this very special group require very special skills and will need to be well trained and well supported.

Manpower, Skills and Training

7.28 Managers and their specialist advisers need to consider how to retain and retrain staff with special skills, and how they may be used to best advantage. Staff need a range of skills and need to be in sufficient numbers to plan for and deliver those skills. Sound manpower planning and effective in-service training are essential.

7.29 There is a limited supply of appropriately qualified and experienced staff, and Regions and Districts must develop a funded strategy for the education and training of mental handicap nurses and other relevant health professionals in mental handicap.

7.30 Because of the limited supply of appropriately qualified and experienced staff, untrained staff will have to be used on occasions and these staff members must know when, and how, to call on specialist services. Staff with the right attitudes and sense of commitment may be just as useful as those with qualifications, as long as they also receive inservice training.

7.31 The work is stressful so there must be effective managerial and professional support and staffing levels will need to be augmented at times of crises. Attention to staff holidays is very important as they need respite in the same way as do relatives.

7.32 Management have a key role in ensuring collaboration between all the agencies so that recipients receive the full range of skills and services as needed.

7.33 From the outset staff need to know what is expected of them and the aims and objectives of the care programme for which they are being employed as well as the nature of the overall service.

7.34 Staff in any one setting must be protected from professional isolation. Joint inservice training and discussion groups for staff from different settings will help towards this. Considerable progress has been achieved in developing schemes of shared training at both basic and post-qualifying levels, for example the ENB/CCETSW course. This is probably one of the best ways in which health authorities can jointly make improvements in deploying skills to meet needs.

Extract from the Steering Committee Overview of the reports of the service advisory groups (Oct 1991)

17. Part of the background to all three reports is the wide variation in the needs of the mentally disordered offender population. While some patients require specialised services to handle their offending behaviour, there are also many who can be looked after within the general mental health services. The issues for them are to ensure that the planning of these services takes proper account of their needs, and that they are diverted to them from the criminal justice system at the earliest possible moment.

18. The guidelines at paragraph 16 clearly imply increased emphasis on community based care, which is seen as the solution of choice for many (perhaps most) patients. It is important to underline therefore that we see no case for reducing the present levels of investment in specialised care provided by either hospitals or prisons.

Prison care

19. We emphasise that prison is no place for a person coming within the scope of the Mental Health Act 1983 to receive treatment. Research by Gunn (see *BMJ* 1991; 303: 338-41) suggests that between 756 and 1371 sentenced prisoners may currently require transfer to hospital for psychiatric treatment. There are others on remand who might have been diverted before or when they came to court. However, there will still be prisoners who develop or have continuing mental health care needs while in prison. For example, Gunn found that 38% of his sample of adult male prisoners had a psychiatric diagnosis, but that the majority did not fulfil the criteria for transfer to hospital under the Mental Health Act.

20. A recommendation stemming from the Efficiency Scrutiny of the Prison Medical Service (PMS) to contract in a full mental health care service from the NHS, initially for remand prisoners, will have considerable resource and other practical (especially training) implications (PR 4.6). We support this proposal, which should lead to better links between services provided in prison and those outside. Such links are essential if transfers to hospital and discharges to the community are to be made effectively. A consultation paper on the future of the PMS (*Contracting for Prison Health Services*, August 1991) has been published for comment by 2 December 1991: see extract at Annex D.

21. Moves to improve prison conditions and the prison regime generally (arising in particular from the Woolf report on disturbances at Manchester Prison and elsewhere (Cm 1456), a review by Her Majesty's Chief Inspector of Prisons of the increasing incidence of suicide and self-harm among prisoners (Cm 1383), and now definitively in the White Paper on the prison service, *Custody, Care and Justice* (Cm 1647): see Annex E) should, together with the PMS proposals, help to provide a better environment for the delivery of health care (PR 3.13-3.16; CR 3.12).

Hospital care

22. An initial target of 1,000 medium secure hospital beds in Regional Secure Units (RSUs) was set in the mid-1970s following the Butler and Glancy reports. Glancy (HR, Annex B) recommended 1,000 beds; Butler, 2,000 beds. Despite the availability of central funding, at 31 January 1991 there were only 635 permanent RSU places. This number clearly falls short of present known needs. The hospital report recommends an increase in medium secure provision, based on urgent assessments of need in each Health Region to be completed before the end of the review. It considers that at least 1500 places will be needed nationally. Pending the establishment of new Regional targets, adequate funding should be provided for the urgent implementation of current plans (HR 5.24 *et seq*).

23. The report recommends also that the medium secure programme (the funding arrangements for which will need to be reviewed by the finance advisory group) would, in future, need to be developed on a much broader basis than to date. In particular there should be more secure provision for people requiring longer-term care (ie beyond the 18-24 months intended for RSU patients) and for people with special needs, including those with learning disabilities. Access to local intensive care and locked wards should be available more widely. More should also be done to dispel the misapprehension that Government policy for re-providing mental illness services (as re-stated in *Caring for People* (Cm 849) and *The Health of the Nation* (Cm 1523)) involves the closure of hospitals as an end in itself (HR 2.12; CR 3.4-3.6). It is not acceptable that mentally disordered offenders who need to be in hospital should be left to cope inadequately in prison or in the community for lack of a suitable and available bed.

Special Hospitals

24. There are estimated to be some 400 Special Hospital patients who may not require that level of security. A similar number of sentenced prisoners may need Special Hospital care. The hospital report accepts that Special Hospital places should be maintained at around 1700 for the time being, with the level kept under review and consideration given to the possibility of providing such care more locally than in the present three locations alone (HR 5.17-5.22).

Community care

25. The care and treatment needs of mentally disordered offenders in the community will generally be similar to those of non-offenders. There must therefore be access to a range of supported and non-supported accommodation (CR 3.20-3.22), as well as day care, social security, and other services (CR 3.39-3.40), and a coordinated approach to care fostered by a multi-professional, multi-agency team responsible for services for mentally disordered offenders (CR 3.34-3.38). Each person referred to the specialised psychiatric services must have a "care programme" (HC(90)23/LAC(90)11: CR, Annex E; PR, Annex B) and such arrangements should be available to discharged prisoners requiring continuing psychiatric care (CR 3.14-3.18; PR 5.33-5.36). Wherever possible, the offender himself and informal carers should be involved in care, and wider service, planning (CR 3.44-3.45). The community report supports the development of community services for mentally disordered offenders as part of mental illness services generally, subject to specialised services being available, including those that take account of a person's offending (CR 3.7-3.8).

Assessment and diversion

26. There need to be effective local arrangements between the police, health, social and probation services for the urgent assessment of people who appear to be mentally disordered. These should include a policy on the operation of section 136 of the Mental Health Act and agreement as to health and social services facilities that are suitable as "places of safety" (CR 2.4-2.13).

27. Every effort should be made to ensure that mentally disordered people are not drawn unnecessarily into the criminal justice system and preferably not removed to a police station in the first instance. The probation service should be involved as soon as possible (CR 2.16). Health and social services should regard it as part of their normal responsibilities to provide assessment and supportive care. There should be nationwide provision of court assessment or similar diversionary schemes (CR 2.28-2.32) and the further development of bail information schemes and "public interest" case assessment (PICA) (CR 2.20-2.25; Annex C). Specialised bail hostels, with access to other services, should be developed for some mentally disordered people who might otherwise have to remain in custody (CR 2.22; *Care, Custody and Justice*, paragraphs 9.7-9.8). Entry to the health and social services at any time of day or night should be via a single and consistent point of access that is known to staff in all local agencies dealing with mentally disordered offenders (CR 3.41-3.42).

NHS Management
Executive

To: Regional General Managers
District General Managers

CC: General Managers of The Bethlem and
Maudsley and Hammersmith SHAs
Chief Executive of the
Special Hospitals Service Authority

Department of Health
Richmond House
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EL(90)168
August 1990

Dear General Manager

HOME OFFICE CIRCULAR ON PROVISION FOR MENTALLY DISORDERED OFFENDERS

1. Government policy is that, wherever possible, mentally disordered people should receive care and treatment from health and social services authorities rather than be cared for within the criminal justice system. The enclosed Home Office circular, which has Department of Health support, draws the attention of the Courts, Prisons, Police and Probation Services to the statutory powers which enable mentally disordered offenders to be diverted away from the criminal justice system. It urges that these powers should be used to their fullest possible extent.

2. The circular covers;

- * the working relationship between courts, criminal justice and health and social services;
- * medical advice for the police in dealing with mentally disordered people;
- * psychiatric assessment and treatment for mentally disorder people in custody;
- * arrangements to enable the Crown Prosecution Service and the Courts to decide whether mentally disordered people should be tried, and whether attendance at hospital for treatment should be a condition of bail or remand, and whether a hospital treatment order should be made either following or as a substitute for conviction;
- * the statutory duty of the RHA to provide information to the courts about the availability of hospital accommodation;
- * the central co-ordinating role of the probation service in providing the courts with information on mentally disordered offenders.

3. Annexed to the Circular are accounts of three examples of good practice involving the attendance of a psychiatrist at court; an innovative multi-disciplinary scheme to provide assessment panels to advise the court about particular cases; and health and social services provision for mentally disordered offenders.

4. I should be grateful if you would satisfy yourself that your liaison arrangements with the criminal justice services ensure that mentally disordered people can receive assessment and treatment as needed without having to be remanded in custody or in prison for long periods. Five copies of the Home Office circular are enclosed for distribution to those likely to be directly involved with the criminal justice system.

5. The Department is reviewing health and social services provided for mentally disordered offenders and others requiring similar services without having come before the courts. This takes account of recent developments and changes in practice, service patterns and management since the earlier work which led to the establishment of forensic psychiatry as a separate psychiatric speciality and the Regional Secure Unit Programme.

6. Arrangements for the review are being co-ordinated in the Department by Mr Steve Catling, head of Priority and Health Service Branch 5. Our contact for general inquiries about both the Home Office Circular and the review is Mr Robert Freeman, Alexander Fleming House, London SE1 6BY (071-407 5522 ext 6224).

Yours sincerely
M.C. Malone-Lee

M C Malone-Lee
Director Operations

This letter will be cancelled on 31 December 1991



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Queen Anne's Gate, LONDON, SW1H 9AT
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MNP/90 1/55/8

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Date: 3 September 1990

cc Director of Public Prosecutions
Clerk to the County Council
Clerk to the Police Authority
Chairman, Regional Health
Authority
Chairman, District Health
Authority
The Director of Social Services
The General Manager,
Regional Health Authority
The General Manager,
District Health Authority

To Judges of the Crown Court
The Circuit Administrator
The Courts Administrator
The Chief Clerk to the Crown Court
The Clerk to the Justices (with a copy for the information of
the Chairman of the Bench)
The Chief Officer of Police
The Chief Probation Officer
The Medical Officer, HM Prison
The Clerk to the Magistrates' Courts Committee

Dear Sir/Madam

Home Office Circular No 66/90

PROVISION FOR MENTALLY DISORDERED OFFENDERS

The purpose of this circular is to draw the attention of the courts and those services responsible for dealing with mentally disordered persons who commit, or are suspected of committing, criminal offences to

- (a) the legal powers which exist; and
- (b) the desirability of ensuring effective co-operation between agencies to ensure that the best use is made of resources and that mentally disordered persons are not prosecuted where this is not required by the public interest.

BACKGROUND

2. It is government policy that, wherever possible, mentally disordered persons should receive care and treatment from the health and social services. Where there is sufficient evidence, in accordance with the principles of the Code for Crown Prosecutors, to show that a mentally disordered person has committed an offence, careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution, such as cautioning by the police, and/or admission to hospital, if the person's mental condition requires hospital treatment, or support in the community, should be considered first before deciding that prosecution is necessary. The government recognises that this policy can be effective only if the courts and criminal justice agencies have access to health and social services. This requires consultation and co-operation, and this circular aims to provide guidance on the establishment of a satisfactory working relationship between courts, criminal justice agencies and health and social services.

3. Provisions for mentally disordered offenders in the prison system in England and Wales were studied by an interdepartmental working group of Home Office and DHSS officials which reported in 1987. It recommended that the courts should be encouraged to use the existing provisions of the Mental Health Act, wherever practicable, to enable appropriate mentally disordered persons to be taken into the health system rather than the penal system, and that information should be made available to the courts about the provision of places in special hospitals, regional secure units and local hospitals.

POLICE

4. The first point of contact between the criminal justice system and a mentally disordered person is often the police, who may be called to intervene in incidents involving a mentally disordered person. There are a range of powers which are available to the police, and it is important that they establish close working relationships with local health, probation, and social services to assist them in exercising their powers:

- i. section 136 of the Mental Health Act 1983 provides a constable with a power to remove to a place of safety a person found in a place to which the public have access and who appears to be suffering from mental disorder within the meaning of the Act and in immediate need of care or control if the constable thinks it is necessary to do so in the interests of that person or for the protection of others. The person may be detained for a maximum of 72 hours. The power in this section may be used in relation to persons who have not committed an offence, and to those who have (or are suspected of having) committed an offence, but where it is not considered necessary in the public interest to arrest that person for the offence. Agreement should be reached with local hospitals and local social services departments so that persons detained under section 136 are

assessed by a psychiatrist and interviewed by an Approved Social Worker as soon as possible for the purpose of making any necessary arrangements for the person's treatment or care. It is desirable that, wherever possible, the place of safety in which the person might be detained should be a hospital and not a police station. Guidance on the use of section 136 is contained in Chapter 10 of the Department of Health Code of Practice on the implementation of the Mental Health Act 1983 (a copy is attached at Annex A);

- ii. Section 135 of the 1983 Act empowers a justice of the peace - on information on oath laid by an Approved Social Worker - to issue a warrant authorising any constable to enter specified premises to remove to a place of safety - which should normally be a hospital - a person believed to be suffering from mental disorder who has been, or is being, ill-treated, neglected or not kept under proper control, or who is living alone and unable to care for himself. The warrant will authorise the person's detention in a place of safety for a maximum of 72 hours. The initiative in seeking a warrant will normally rest with an Approved Social Worker. The warrant may apply to any premises within the justice's jurisdiction, including private property to which the police powers under section 136 do not extend;
- iii. where it is suspected that a mentally disordered person may have committed an offence, consideration should be given - in consultation with the Crown Prosecution Service, where appropriate - to whether any formal action by the police is necessary, particularly where it appears that prosecution is not required in the public interest in view of the nature of the offence. If the suspect is able to meet the requirements for a caution to be administered, he might be cautioned. If the criteria for a caution are not met, the police should consider whether any action need be taken against the suspect. In some cases the public interest might be met by diverting mentally disordered persons from the criminal justice system and finding alternatives to prosecution, such as admission to hospital under sections 2 or 3 or to guardianship under section 7 of the 1983 Act or informal support in the community by social services departments. The development of effective liaison with health and social services authorities will play an essential role in developing satisfactory arrangements to respond constructively in such cases;
- iv. the questioning of mentally disordered persons suspected of committing offences is subject to the Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers issued under section 66 of the Police and Criminal Evidence Act 1984. (Annex E of the Code summarises the provisions relating to mentally ill and mentally handicapped persons). Paragraph 9.2 requires the custody officer immediately to call a police surgeon if a person brought to a police station or already detained there appears to be suffering from a mental disorder. In urgent cases the person must be sent to hospital. These requirements apply even if the person makes no request for

medical attention. In the case of mentally disordered persons, chief officers of police may find it helpful to arrange with their local health authorities for psychiatrists to fill the role of police surgeon. Chief officers will be aware that even with the protection afforded by the Police and Criminal Evidence Act 1984, some mentally disordered suspects may make confessions which are untrue, and therefore it is always advisable to seek other evidence which may support or reject the suspect's story;

- v. where it is decided that the public interest requires the prosecution of a mentally disordered person for an offence it should be borne in mind that he has the same right as other suspects to bail after charge. If his mental state or other factors, such as homelessness, give rise to difficulties in releasing him on bail, arrangements should be made with the health, probation, and social services to ensure that appropriate support can be provided, such as admission to hospital, where his mental condition warrants it, or to a hostel, if the managers agree. Police bail cannot, of course, be subject to conditions of residence or medical treatment, but satisfactory arrangements to provide for these on a voluntary basis may enable the police to release the suspect on bail rather than to detain him pending his appearance before the magistrates' court;
- vi. after a mentally disordered person has been charged, wherever possible arrangements should be made with the health, probation, and social services for his assessment with a view to ensuring that he receives any medical treatment that may be necessary, and that the Crown Prosecution Service and court can be advised of any particular bail conditions or, after conviction, disposal that may be appropriate to his circumstances. At annex B to this circular is a note outlining court psychiatric assessment arrangements which have been established at certain central London and at Peterborough magistrates courts to secure expert medical advice when required. Chief officers of police may wish to explore with their local chief probation officers and health authorities the possibility of setting up similar arrangements to ensure that suspects who are thought to be mentally disordered and in need of medical assessment should be seen by a psychiatrist as soon as possible.

5. A small minority of cases involving mentally disordered persons result in findings by the Crown Court of unfitness to plead under the provisions of the Criminal Procedure (Insanity) Act 1964. Details of the consequences of such a finding are set out in paragraph 13 below. It is important to note, however, that, although the accused is admitted to hospital as if subject to a hospital order and a restriction order without limit of time, a finding of unfitness to plead is not a disposal by the court. The intention of the Act is that the accused should return to court to stand trial, wherever possible, if his condition improves sufficiently to enable him to do so. It is, therefore, essential that, where a person is found unfit to plead, all the relevant

evidence should be preserved either until the accused is remitted for trial, or until formal notification is received from the Crown Prosecution Service or Home Office that a trial will not be held.

CROWN PROSECUTION SERVICE

6. Where proceedings are instituted against a person by the police, the papers will be referred to the Crown Prosecution Service which will review the sufficiency of the evidence and consider carefully whether or not the public interest requires a prosecution in accordance with the Code for Crown Prosecutors. Any information provided by the police with the papers regarding that person's mental condition, or discussions held with other agencies to consider the advisability of diverting him from court, will be taken into account. It will be important to distinguish between those forms of mental disorder which are made worse by the institution of criminal proceedings and those forms of mental disorder which come about by reason of the institution of criminal proceedings. Where the Service is satisfied that the probable effect upon a person's mental health outweighs the interests of justice in the particular case, it will consider discontinuing the proceedings. Where the form of mental disorder is present without there being any indication that proceedings will have an adverse effect, the Crown Prosecutor will take account of the public interest in attempting to ensure that the offence will not be repeated as well as having regard to the welfare of the person in question.

MAGISTRATES' COURTS

7. Mentally disordered persons have the same rights as other persons, including a right to bail. A mentally disordered person should never be remanded to prison simply to receive medical treatment or assessment. It is desirable for the court to receive professional advice at as early a stage as possible on facilities which may be available to assist it with mentally disordered persons. Annex B to this circular describes court psychiatric assessment arrangements at certain central London and at Peterborough magistrates' courts. These enable the courts to receive speedy medical advice and to ensure that, where appropriate, arrangements can be made quickly to admit a mentally disordered person to hospital, for example as a condition of bail or, with the agreement of the hospital managers, under section 35 of the Mental Health Act 1983 following conviction. Where neither of these courses is applicable but the accused person nevertheless requires admission to hospital for assessment or treatment, the health and social services can be asked to consider using their civil powers of admission under sections 2 or 3 of the Act.

8. In considering cases involving mentally disordered persons magistrates may wish to bear in mind the possible courses of action which may be open to them. These include:

- i. where the Crown Prosecution Service decides to proceed with a case, the court will be required to consider the question of bail in the normal way. In cases where medical treatment is considered desirable this may be achieved as a condition of bail, such as requiring residence at a hospital or attendance at an outpatient clinic, although the bailed person cannot be compelled to comply with

treatment under these circumstances. Magistrates will wish also to bear in mind the desirability of arranging for a medical report on the accused's condition to be prepared on bail. Their attention is drawn to Annex C of this circular, which describes the multi-agency assessment scheme operating in Hertfordshire;

- ii. in cases where an accused person has been convicted of an offence punishable with imprisonment, or has been charged with such an offence and the court is satisfied he did the act or made the omission charged, and it is considered necessary to remand him in custody rather than on bail, the attention of magistrates is drawn to the power of the court under section 35 of the 1983 Act to remand to hospital provided it is satisfied in accordance with section 35(4) that arrangements have been made for the admission of the accused within a period of seven days. This power should be used wherever possible to obtain a medical report on an accused person's condition, providing the court has written or oral evidence from a doctor who is approved under section 12(2) of the Act as having special experience in the diagnosis and treatment of mental disorder, that there is reason to suspect that the accused is suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment and the court is of the opinion that it would be impracticable for a report on the accused's mental condition to be made if he were remanded on bail. Normally the local psychiatric hospital or unit in a general hospital will be able to provide adequate arrangements for the assessment of mentally disordered persons, but in addition most regional health authorities are able to provide secure hospital accommodation in cases where this is necessary, and places may be sought in a special hospital in respect of persons who are thought to require treatment in conditions of special security because of their violent, dangerous, or criminal propensities. At Annex D is a note of health service hospital facilities. Magistrates' courts are requested to consider with their regional health authority the establishment of working arrangements to ensure that appropriate hospital facilities can be made available speedily when necessary;
- iii. where a person suffering from mental illness or severe mental impairment is charged with an offence punishable on conviction with imprisonment (other than where the sentence is fixed by law); a magistrates' court has power under section 37(3) of the 1983 Act to make a hospital order without convicting him provided the court is satisfied that the accused did the act or made the omission charged, and that on the evidence of two registered medical practitioners, one of whom is approved under section 12(2) of the Act, the accused is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment. In the case of psychopathic disorder or mental impairment the court must also be satisfied, on the same evidence, that such treatment is likely to alleviate or stabilise the condition. Before making an order, the court must be satisfied under section 37(4) that arrangements have been

made for the offender's admission to hospital within 28 days of an order being made. The requirements for determining whether the offence should be tried summarily or on indictment need not necessarily be complied with, nor is a trial necessary, before exercising this power. However, its exercise will usually require the consent of those acting for the defendant if he is under a disability so that he cannot be tried (see R v Lincolnshire (Kesteven) Justices, ex p. O'Connor [1983] 1AER 901);

- iv. where a mentally disordered person is convicted of an offence the court will wish to consider whether a non-penal disposal may be appropriately imposed. These include:
- a) a hospital order under section 37 of the 1983 Act in cases where the accused person is convicted of an offence punishable with imprisonment (other than where the sentence is fixed by law), if the court is satisfied on evidence from two registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment, and that in the case of psychopathic disorder or mental impairment the treatment is likely to alleviate or stabilise the condition. The court must also be satisfied that, in accordance with section 37(4), arrangements have been made for the offender's admission to hospital within twenty eight days;
 - b) an interim hospital order under section 38 of the 1983 Act. To assist the court and hospital in determining whether it is appropriate to make a hospital order in respect of an offender, the courts may make an interim hospital order so that the offender's response in hospital can be evaluated without any irrevocable commitment on either side to this method of dealing with the offender if it should prove unsuitable.
- Before making an interim hospital order the court must be satisfied on evidence from two doctors, one of whom is approved under section 12(2) of the Act, that the offender is suffering from mental disorder such as makes it reasonable to suppose that a hospital order might be appropriate. It must also be satisfied in accordance with section 38(4) that arrangements have been made for the offender's admission to hospital within 28 days;
- c) a guardianship order under section 37 of the 1983 Act in cases where the offender is convicted of an offence punishable with imprisonment (other than where the sentence is fixed by law), placing the offender under the guardianship of the local social services authority or a person approved by it, provided he has reached the age of 16 and the court is satisfied on evidence from two registered medical practitioners,

one of whom is approved under section 12(2) of the Act, that the mental disorder is of a nature or degree which warrants reception into guardianship. By virtue of section 37(6) a guardianship order is not to be made unless the court is satisfied that the authority or person in question is willing to receive the offender.

The purpose of guardianship is primarily to ensure that the offender receives care and protection rather than medical treatment, although the guardian does have powers to require the offender to attend for medical treatment. The effect of a guardianship order is to give the guardian power to require the offender to live at a specific place (this may be used to discourage the offender from sleeping rough or living with people who may exploit or mistreat him, or ensure that he resides at a particular hostel), to attend specific places at specified times for medical treatment, occupation, education, or training, and to require access to the offender to be given at the place where the offender is living to any doctor, approved social worker, or other person specified by the guardian. This power could be used, for example, to ensure the offender did not neglect himself;

- d) a probation order with a condition of psychiatric treatment under section 3 of the Powers of Criminal Courts Act 1973. This is a normal probation order which has been adapted to meet the needs of an offender who does not need to be detained in a hospital, but who is suffering from a mental condition which can be treated and needs treatment. A probation order may not be made unless the Court is satisfied that arrangements have been made for the treatment which the court intends to specify in the order, including arrangements for the offender's reception where he is to be required to submit to treatment as an in-patient. The court may make a probation order in the normal way, with the consent of the offender; and if it is satisfied on the evidence of a doctor approved as having special experience in the diagnosis or treatment of mental disorder that the offender needs treatment for his mental condition but does not need to be detained in hospital, the court may include in the probation order a requirement that he undergoes medical treatment with a view to the improvement of his mental condition. A condition of residence at a hospital can be attached to the probation order, if appropriate, even where formal detention under the Mental Health Act is not indicated. The court may also wish to call for a social enquiry report to assist it in reaching a decision in such cases. The offender may be required to undertake treatment for the whole of the period of the probation order, or for part of it. If he fails to comply with the requirements of the probation order, the offender is in breach of probation and may be dealt with in the

same way as any other offender who is in breach of probation;

- e) discharge, either absolute or conditional, so that arrangements may be made on an informal basis for the offender to receive any necessary medical treatment or social work support. Under such a disposal, however, treatment may not be administered compulsorily, unless the offender is subsequently detained under the civil powers of the 1983 Act.

9. It is open to any magistrates' court which is minded to make a hospital or interim hospital order in respect of any person to ask the Regional Health Authority under the provisions of section 39 of the 1983 Act for information about hospitals which can accommodate that person (see paragraph 15 below).

CROWN COURT

10. In considering cases involving mentally disordered persons the Crown Court may wish to bear in mind its powers to obtain a medical report by:

- i. remanding on bail with a condition of attendance at, or residence in, a hospital for the purpose of medical assessment;
- ii. remanding to hospital under the provisions of section 35 of the 1983 Act an accused person suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment who is awaiting trial for an offence punishable with imprisonment, or who has been arraigned but not yet sentenced or otherwise dealt with.

This power may be exercised where the court is satisfied on the evidence of a doctor, who is approved under section 12(2) of the Act that there is reason to suspect the accused is suffering from mental disorder, and the court is of the opinion that it would be impracticable for a medical report to be made if he were remanded on bail. The court must also be satisfied in accordance with section 37(4) that the accused will be admitted to hospital within 7 days. (This power may not be exercised in respect of a person convicted before the court if the sentence for the offence of which he has been convicted is fixed by law.)

11. The Crown Court has power under section 36 of the 1983 Act to remand an accused person (other than a person charged with an offence the sentence for which is fixed by law) to hospital for treatment. The court must be satisfied on the evidence of two registered medical practitioners, one of whom must be approved under section 12(2) of the Act, that the accused is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment. The court must also be satisfied, in accordance with section 36(3), that the accused will be admitted to hospital within 7 days. The court may find this power helpful when considering

cases of mentally disordered persons who may be unfit to plead but whose mental condition might improve as a result of medical treatment.

12. Cases may arise where an accused person, who has been remanded in prison custody, is transferred by the Home Secretary to hospital for urgent treatment under the provisions of section 48 of the 1983 Act. If it appears to the Crown Court in such a case that it is impracticable or inappropriate to bring that person before the court, the court may, in accordance with section 51(5), make a hospital order (with or without a restriction order) in his absence and, in the case of a person awaiting trial, without convicting him. Before doing so the court must be satisfied on the written or oral evidence of at least two registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the accused is suffering from mental illness or severe mental impairment which makes it appropriate for him to be detained in hospital for treatment, and that it is proper to make such an order.

13. In cases where the accused is found to be unfit to plead under the provisions of section 4 of the Criminal Procedure (Insanity) Act 1964, the court is required by section 5 of the Act to make an order that the accused be admitted to such hospital as may be specified by the Secretary of State. This may be a special hospital, a regional secure unit or a local hospital, depending on the gravity of the alleged offence and the apparent risk to the public. The accused is treated as though subject to a hospital order and a restriction order without limit of time made under the provisions of sections 37 and 41 of the Mental Health Act 1983. In view of the nature of this disposal, courts are asked to bear in mind their power under section 4(2) of the 1964 Act to postpone consideration of the defendant's fitness to plead until anytime up to the opening of the case for the defence. This provides an opportunity to test the prosecution case and may reduce the likelihood of an innocent person being detained. This may be particularly important in the case of persons who appear to be suffering from severe mental impairment. Their condition is unlikely to change after receiving medical treatment and consequently they may never be able to benefit from a normal trial. Where a person is found unfit to plead the Home Secretary will arrange for his case to be reviewed at six monthly intervals during the first two years of his detention in hospital to consider his fitness to stand trial, and he would normally expect to remit that person for trial should he receive medical advice that he is fit to plead. If, at the end of two years, the Home Secretary is advised that he remains unfit to plead he will review the continuing need for the restriction order under section 42(1) of the 1983 Act and will terminate it if he concludes it is unnecessary for the protection of the public from serious harm.

14. If a mentally disordered person is convicted of an offence the court will wish to consider the suitability of non-penal disposals. These include:

- i. a hospital order in cases where a person is convicted of an offence (other than one for which the sentence is fixed by law) punishable with imprisonment, if the court is satisfied, in accordance with the provisions of section 37(2) of the 1983 Act, on the evidence of two registered medical practitioners, one of whom is approved under

section 12(2) of the Act, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment, and that, in the case of psychopathic disorder or mental impairment, the treatment is likely to alleviate or stabilise the condition. The court must also be satisfied that, in accordance with the provisions of section 37(a), arrangements have been made for the offender's admission to hospital within twenty eight days. In addition to the special hospitals (Ashworth (formerly Moss Side and Park Lane Hospitals), Broadmoor and Rampton), which provide treatment in conditions of special security for persons with violent, dangerous, or criminal propensities, most regional health authorities provide a range of hospital facilities for the treatment of mentally disordered offenders, including secure units. At Annex D is a note of health service hospital facilities;

- ii. an interim hospital order (see paragraph 8.iv.(b) above);
- iii. a restriction order. In any case where it makes a hospital order under section 37 of the 1983 Act, the court may also make a restriction order under section 41 where it appears necessary for the protection of the public from serious harm. The decision on whether to make the order rests with the court and does not depend upon the agreement of the hospital or the doctor in whose care the patient will be placed, although at least one of the doctors whose evidence is taken into account in making a hospital order must have given oral evidence in court. In reaching its decision the court must take into account the nature of the offence, the antecedents of the offender, and the risk of his committing further offences if set at large. (The law governing the making of restriction orders was clarified by the Court of Appeal in R v Birch [1989] CLR June 296.) A restriction order may be either for a specified period or without limit of time, and may be terminated at any time by the Home Secretary under section 42(1). The effect of a restriction order is that the patient may not be discharged (except by a Mental Health Review Tribunal), granted leave of absence, or transferred to another hospital without the consent of the Home Secretary. Restricted patients are generally discharged from hospital subject to conditions of residence and supervision by a doctor and a social worker or probation officer, remaining liable to recall to hospital by the Home Secretary for a period after their discharge. Where circumstances warrant it, however, such patients can be absolutely discharged from hospital instead of having to complete a period of supervised living in the community;
- iv. a guardianship order (see paragraph 8.iv.(c) above);
- v. a probation order (see paragraph 8.iv.(d) above);
- vi. discharge. Where the court is satisfied that, following conviction, the public interest requires no formal sentence or other disposal it is open to the court to discharge the offender, either absolutely or conditionally, particularly if it believes that satisfactory arrangements for the care

and treatment of the offender can be made on an informal basis.

In considering these options, the court may find it useful to involve the Crown Court liaison probation officer in approaching the health authorities or social services departments or in making appropriate arrangements for the preparation of a social inquiry report.

15. To assist the courts in deciding whether to make a hospital or interim hospital order, section 39 of the 1983 Act places a duty on Regional Health Authorities to respond to requests from courts for information about hospitals which could provide accommodation for people in respect of whom the courts are considering making hospital orders. This obliges Regional Health Authorities to inform the court as to the facilities they provide for detained patients, including those who may require treatment in appropriate conditions of security; and it will also enable the Regional Health Authority to advise in cases where there is some room for doubt as to the patient's normal place of residence or other factor determining the appropriate hospital within whose catchment area he falls. The intention is to provide a court with all possible assistance short of removing the obligation in section 37(4) of the 1983 Act to be satisfied that the necessary arrangements have been made before making a hospital order, in cases where the necessary criteria for a hospital order are satisfied and it is minded to make one, but no hospital place has been made available. Regional Health Authorities have been encouraged to make standing arrangements for meeting such requests for information from courts, and it is intended that these arrangements will reduce the number of cases in which a hospital order appears suitable but the court is frustrated in the search for a place. In cases where it is desired to make use of this provision, the clerk of the court should contact the Regional Medical Officer or solicitor for the Regional Health Authority covering the area from which the offender appears to come. (There is no longer any scope for disputes between Regional Health Authorities as to responsibility for dealing with the enquiry, as any Authority approached by the court is under a statutory duty to provide information about hospitals "in its region or elsewhere" at which arrangements could be made for the person to be admitted. If the Authority first contacted believes it to be more appropriate for another Authority to respond, it will only be able to pass on responsibility if the second Authority agrees.)

16. Where a court is satisfied that at the time of committing the act with which he is charged the accused was labouring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing or, if he did know it, that he did not know he was doing what was wrong, it shall return the special verdict of not guilty by reason of insanity. In accordance with the provisions of section 5(1) of the Criminal Procedure (Insanity) Act 1964 the court is required to make an order that the accused be admitted to such hospital as may be specified by the Home Secretary (the level of security being determined by the seriousness of the offence and the apparent risk of further offending), where he will be detained as though subject to a hospital order and restriction order without limit of time made under sections 37 and 41 of the Mental Health Act 1983.

PROBATION SERVICE

17. The probation service should act as part of a network of agencies (social services, health services, voluntary organisations) providing accommodation, care and treatment in the community for mentally disordered offenders. Information about facilities for accommodation, treatment, education, supervision etc should be pooled, and there should be a shared list of contact points with telephone numbers for each agency. (In some areas it may be sensible for the probation service to take the lead in co-ordinating this network, but elsewhere the lead might be taken by a voluntary organisation or by the social services with their responsibility for care in the community.) The special role of the probation service is:

- to provide information to the courts for bail and sentencing decisions;
- to provide information to the Crown Prosecution Service in connection with bail information schemes;
- to provide bail and probation hostels and other accommodation projects for offenders and persons on bail;
- to supervise offenders on probation orders;
- to provide for the throughcare and supervision of offenders released from prison on licence and parole.

Chief Probation Officers are asked to establish liaison arrangements with other agencies to ensure that the probation service can carry out these tasks effectively. At annex E is a note outlining seminars and training courses organised by the West Yorkshire and the Greater Manchester Probation Services and by the Northern Regional Committee for Probation Staff Development which chief officers might find helpful as examples of good practice in encouraging co-operation with other agencies and with the courts.

18. When a mentally disordered person is arrested and charged, the probation service should play its part in diverting him or her from custodial remand. They can do this in several ways. If there is a bail information scheme, the probation officer will visit the accused in police custody to interview him and obtain information which, if verified, can be passed on to the Crown Prosecution Service to inform the bail decision. Mentally disordered persons may be particularly at risk of being remanded in custody, because their circumstances and way of life may be unstable. Good liaison between the bail information scheme, the police, the health service and social services will therefore be particularly important. If in-patient treatment is not warranted, the probation officer may be able to identify suitable accommodation in a bail hostel or lodging scheme organised by the probation service, or by the social services. Intervention at this stage can prevent unnecessary remands to prison establishments.

19. If there is no bail information scheme the first contact may not occur until the accused's first court appearance. The court will have the range of options described in paragraph 8(i) and (ii) above. In particular, mentally disordered persons may be remanded

to hospital by the courts under the provisions of section 35 and 36 of the Mental Health Act 1983. In other cases it is open to the courts to remand the accused on bail with a condition of residence in a hospital or of attendance at a hospital. Persons whose condition is not such as to require in-patient treatment may be considered for placement in a bail hostel where this is desirable to avoid a remand in custody. Or they may be remanded on bail with other conditions (eg living at a specified address). The court duty probation officer can help the court by advising on ways of avoiding a custodial remand making use of resources and treatment available in the community. This will succeed only if the probation service has good liaison with, and support from, other agencies, especially the health service and the local authority social services, whose responsibilities are described at Annex F.

20. When mentally disordered persons are convicted of offences, the court will wish to consider the possibility of a community disposal. In cases where detention in hospital for treatment under the provisions of section 37 of the 1983 Act is not considered necessary, but the offender's mental condition is still treatable, a probation order with a condition of psychiatric treatment may be given. If the offender's condition is not treatable, a probation order may be made without a condition of treatment, but with other conditions or arrangements which make for effective supervision. These may include residence at a probation hostel or other community care arrangements made by the social services or a voluntary organisation. It is important that the court should have a social inquiry report available to it in addition to medical advice. The SIR should set out the full range of sentencing options which may be suitable, and give details of the type of supervision and accommodation which could and would be provided in the community. There should be liaison between probation officer, author of the medical report and the offender's lawyer about an appropriate recommendation to the court.

21. It is important that all accused persons who are likely to be suitable candidates for probation orders are identified at as early a stage as possible and that arrangements are made quickly for their medical assessment. Chief probation officers are asked to review their procedures, in consultation with police, the courts, social services and health authorities, to ensure that they identify candidates for community disposals at an early stage in the prosecution process and assist in achieving a swift disposal of the case by the courts. (At Annex C is a brief description of a multi-agency assessment scheme in operation in Hertfordshire.)

22. The effectiveness of probation orders with a condition of treatment depends on close co-operation, understanding and communication between the probation service and local psychiatric services, and is aided by the presence at local level of psychiatric staff with an interest in forensic psychiatry. It would be helpful for each probation area to draw up its own code of practice for probation officers undertaking supervision of a mentally disordered offender, defining lines of responsibility and accountability (eg clarifying of boundaries between the responsible medical officer and the probation officer, especially where both are carrying statutory responsibilities).

PRISON MEDICAL SERVICE

23. Consolidated guidance will be issued shortly to the prison medical service in a circular instruction from the Director of the Prison Medical Service. This reminds medical officers when examining remand prisoners on reception into prison to be alert for signs of mental disorder. Any prisoner who is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment, and is in urgent need of hospital treatment, should be recommended for transfer to hospital in accordance with the provisions of section 48 of the Mental Health Act 1983. Medical officers are encouraged to discuss with C3 Division any case where there is doubt about what initiative to take or where there is any difficulty in securing a hospital place. Medical officers should also seek to identify those remand prisoners who might benefit from medical treatment after conviction, for example by means of a hospital order, psychiatric probation order, or guardianship order. In such cases they should offer advice to the court and, where appropriate, should seek the assistance of the probation service, for example in arranging for a psychiatric probation or a guardianship order to be made by the court.

24. In the case of sentenced prisoners, medical officers are reminded of the need to arrange the transfer to hospital under section 47 of the Mental Health Act 1983 as soon as possible during the course of their sentences of those prisoners suffering from mental illness, psychopathic disorder, mental impairment, or severe mental impairment of a nature or degree which makes it appropriate for them to be detained in hospital for treatment. Medical officers should ask a consultant psychiatrist from the catchment area hospital or regional secure unit, or special hospital covering the prisoner's home to visit as soon as possible to assess the prisoner and to arrange his admission to their hospital, taking account of the level of security which is required. Recommendations for transfer from two registered medical practitioners, at least one of whom is approved for the purposes of section 12 of the Mental Health Act 1983 as having special experience in the diagnosis or treatment of mental disorder, should then be put forward to C3 Division. Medical officers are encouraged to discuss any cases where there is doubt, or where difficulty is experienced in finding a hospital place, with C3 Division.

CONCLUSION

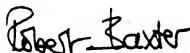
25. It is the government's policy to divert mentally disordered persons from the criminal justice system in cases where the public interest does not require their prosecution. Where prosecution is necessary it is important to find suitable non-penal disposals wherever appropriate and the police, courts, and probation service are asked to work together with their local health and social services to make effective use of the provisions of the Mental Health Act 1983 and of the services which exist to help the mentally disordered. They are also asked to ensure that all their officers are aware of this circular, and to consider any training which is necessary to equip them in their contacts with mentally disordered persons.

26. In summary:

- i. Chief Officers of Police are asked to ensure that, taking account of the public interest, consideration is always given to alternatives to prosecuting mentally disordered offenders, including taking no further action where appropriate, and that effective arrangements are established with local health and social services authorities to ensure their speedy involvement when mentally disordered persons are taken into police custody;
- ii. Courts are asked to ensure that alternatives to custody are considered for all mentally disordered persons, including bail before sentence, and that persons who are in need of medical treatment are not sent to prison. The attention of court clerks is drawn, in particular, to the desirability of establishing arrangements in co-operation with the probation service and the local health and social services authorities, for speedy access to professional advice for the court to assist it in its decision making;
- iii. Chief Probation Officers are asked to ensure that effective arrangements are established to provide courts with information and advice to enable them to make use of alternatives to imprisonment in dealing with mentally disordered offenders. Attention is drawn to the need to co-operate with local health and social services authorities to provide professional advice to courts and to facilitate a wider use of treatment and non custodial disposals, including remands on bail before sentence and psychiatric probation orders and guardianship orders, where appropriate, after conviction; and
- iv. Prison medical officers are asked to ensure that action is taken to arrange transfer to hospital under the provisions of section 48 of the Mental Health Act 1983 in respect of any mentally ill or severely mentally impaired person remanded in custody who appears to require urgent treatment in hospital, and to consider advising the courts of the suitability of any other mentally disordered person on remand for treatment as part of a non-custodial disposal, such as a psychiatric probation order or guardianship order, after conviction. Prison medical officers are asked to ensure that action is taken to arrange the transfer to hospital under the provisions of section 47 of the Mental Health Act 1983 of any sentenced prisoner who appears to require treatment in hospital for mental disorder.

27. Enquiries about this circular should be addressed to Robert Wallich, C3 Division, Home Office, 50 Queen Anne's Gate, London SW1 (telephone 071-273-3118).

Yours faithfully

A handwritten signature in dark ink, appearing to read 'Robert Baxter', with a stylized, cursive script.

Robert Baxter
C3 Division

The annexes to this circular were reproduced at Annex B of the report of the community advisory group

**General recommendations of the official working group
on services for people with special needs**

1. **WE RECOMMEND** that agencies' approach to services for mentally disordered offenders with special needs is consistent with the considerations set out at paragraph 2.2 [paragraph 3.31 of the present report].
2. **WE RECOMMEND** that the planning of services for mentally disordered offenders, based on local needs assessments, and the wider links developed by specialised teams dealing with such patients, should take particular account of the additional inputs that may be required to identify and provide for special needs at key points of the system.
3. **WE RECOMMEND** that, wherever possible, the special needs of mentally disordered offenders are met by local services, but that, where, in the best interests of the patient, it is necessary to make referrals to services outside the locality, effective links are maintained with those in a patient's home district. (This recommendation is very similar to that at paragraph 3.46 of the community group report.)
4. **WE RECOMMEND** that (as is already the case) the finance advisory group considers the implications of "purchaser/provider" arrangements for services with an extra-Regional catchment, including the need for effective mechanisms to ensure that, where necessary, specialised services for mentally disordered offenders can be developed and maintained supra-Regionally.
5. **WE RECOMMEND** that, in suitable cases, Supra-Regional funding is regarded as a realistic option for health services for mentally disordered offenders with a supra-Regional or national catchment.
6. **WE RECOMMEND** that staff from other health and social service teams should, as necessary, be involved with the mental health care services in the operation of care programmes or other continuing care arrangements for mentally disordered offenders with special needs. These arrangements should take account of any special requirements, including therapy needs, that patients may have to enable them to contribute to decisions about future care.
7. **WE RECOMMEND** that agencies should ensure that staff are trained in the recognition and initial handling of a broad range of special needs.

Health care for prisoners

8. *WE RECOMMEND that specific standards relating to mental health care screening on reception to prison (see paragraph 4.9 of the prison advisory group report) should take account of the importance of identifying special needs.*
9. *WE RECOMMEND that contracts for the delivery of mental health care services to prisons should include a requirement for staff to facilitate, as necessary, arrangements to meet the additional special needs of patients.*

Unequal Justice ConferenceSUMMARY REPORT:

The conference was organised by T.A.C.L. Trust Fund with support from Greater Manchester Police. It was chaired by Mr. David Finch who opened the conference by identifying the aims of the conference and describing the negative experiences of people with learning disabilities through society's attitude towards them and the derogatory labels we have attached. He identified some of the difficulties facing agencies and highlighted problems of services accepting responsibility for providing services to this group of people. Mr. Finch stressed the importance of inter-agency working and co-operation, a motion all speakers and delegates endorsed.

Mr. David Wilmot, Chief Constable, Greater Manchester addressed the conference from the police perspective. He highlighted some of the difficulties facing police officers and the lack of training they receive in dealing with people with learning disabilities and mental disorders. Mr. Wilmot gave an overview of the powers available to the police and the governments recommendations regarding diversionary schemes for mentally disordered offenders.

Mr. Wilmot went on to give examples of miscarriages of justice and informed delegates of the dangers of complacency. He advocated a cultural shift in the police treatment of disordered offenders and again highlighted the importance of inter-agency co-operation. and police training. He informed the audience that he had commissioned Superintendent David Mellor, Ashton-under-Lyne police station, to carry out a review of police policies and procedures, alongside the Community Affairs department of GMP.

Lydia Sinclair, Legal Director, MENCAP, presented a number of case studies to illustrate the inadequacies of the criminal justice system. She identified a number of key areas which effect the way in which a person is dealt with by the police and the courts. These included how the police initially respond to offences; the degree of co-operation between all the agencies; whether or not a person has effective legal representation; the ability of the court to respond to information provided; and the availability of hospital/social accommodation. Ms. Sinclair concluded that urgent action is needed to improve police and court practice along with improved medical and social provision in prison and the community.

Dr. Tony Holland, Senior Lecturer, M.I.E.T.S. Unit, gave a clinical presentation describing the characteristics of mental handicap, and an overview of how people have been labelled and how such labeling influenced treatment. He described the process from the time of the offence through to sentencing and suggested that at various times throughout this process different professionals may have a key role to play. Dr. Holland also emphasised how vital it is for all agencies to co-operate and develop strategies.

Dr. Holland described the function and powers of the Mental Health Act (1983) and the various sections which can be used for assessment and treatment. He finished his presentation with case examples, describing vulnerable factors which might be responsible for the offending behaviour and how they were dealt with.

Unequal Justice Conference

Mr. Nick Dean, Principal, Dept. Health Secretariat, outlined the progress made with the Government review and gave details of the various working groups which have been set up looking at all of the various aspects apertaining to the mentally disordered offender. He acknowledged that there were issues of resources which still had to be addressed and everyone was concerned about.

Mr. Dean emphasised the importance of a multi-agency working and the importance of assessment and treatment plans. He reiterated some of the main recommendations of the review reports, in particular that services should be developed locally, be based around individuals needs, provide only that security which is deemed necessary and be as near to families and a person's own home as possible.

The final speaker was Bob Perske, author of Unequal Justice, who provided an insight into how mentally disordered offenders were dealt with in th U.S.A. In his book he describes several cases of miscarriages of justice and has spent much time with people on death row. He asked all present to think in terms of the individual when talking about service provision. His concern was that if we all kept emphasising the 'service' the individual would not benefit.

He presented an array of situations which demonstrated how people with disabilities are dealt with unfairly and which also demonstrated how vulnerable they were within the criminal justice system. For example, he talked about acquiescence and the fact many people with learning disabilities are eager to please. He highlighted the plight of people with mild disabilities who were often denied services because of their apparent competencies.

Mr. Finch closed the conference by asking delegates to ensure that this group of people were not forgotten about, that they remain on all our agendas as a matter of priority. He again asked that we all think about developing closer working links so we could all learn from one another.

Sue Henstock

20 May 1992

Extract from the Mental Health Act 1983 Code of Practice

General

28.1 The guidance given elsewhere in the Code applies to patients with mental handicap (often referred to as learning difficulties). This chapter gives guidance on a number of particular issues of importance to this group of patients.

28.2 Very few people with mental handicap are detained under the Act. Some admission sections can only be considered where the person with a mental handicap falls within the legal definition of 'mental impairment' or 'severe mental impairment'. People with mental handicap can of course be considered for admission under the Act when they are suffering from another form of mental disorder (for example mental illness).

Communication

28.3 The assessment of a person with mental handicap requires special consideration to be given to communication with a person being assessed. Where possible the A S W should have had experience of working with people with a mental handicap or be able to call upon someone who has. It is important that someone who knows the patient, and can communicate with him is present at the assessment. Someone with a knowledge of Makaton or other communication systems may be of assistance.

Assessment

28.4 It is desirable that no patient should be classified under the Act as mentally impaired or severely mentally impaired in the absence of a formal psychological assessment as evidence of severe or significant impairment of intelligence. This assessment should be part of a complete appraisal by medical, nursing, social work and psychology professionals and, wherever appropriate, by those with experience in mental handicap. This procedure is also desirable where it is proposed that a patient is to be detained under Section 2 on the grounds of mental disorder in the form of arrested or incomplete development of mind, although the urgency of the case may preclude this.

Mental Impairment/Severe Mental Impairment (legally defined in Section 1)

28.5 The identification of an individual who falls within these legal categories is a matter for clinical judgement, guided by current professional practice and subject to the relevant legal requirements. Those assessing the patient must be satisfied that the person concerned displays a number of characteristics difficult to define in practice. This section of the chapter sets out guidance in relation to the key factors or components of these legal categories.

Incomplete or arrested development of mind. This implies that the features that determine the handicap were present at some stage which permanently prevented the usual maturation of intellectual and social development. It excludes persons whose handicap derives from accident, injury or illness occurring after that point usually accepted as complete development.

Severe or significant impairment of Intelligence. The judgement as to the presence of this particular characteristic must be made on the basis of reliable and careful assessment.

Severe or significant impairment of social functioning. The evidence of the degree and nature of social competence should be based on reliable and recent observations, preferably from a number of sources such as social workers, nurses and psychologists. Such evidence should include the results of one or more social functioning assessment tests.

Abnormally aggressive behaviour. Any assessment of this category should be based on observations of behaviour which lead to a conclusion that the actions are outside the usual range of aggressive behaviour, and which cause actual damage and/or real distress occurring recently or persistently or with excessive severity.

Irresponsible conduct. The assessment of this characteristic should be based on an observation of behaviour which shows a lack of responsibility, a disregard of the consequences of action taken, and where the results cause actual damage or real distress, either recently or persistently or with excessive severity.

Police and Criminal Evidence Act 1984 Codes of Practice

Code C, Annex E

SUMMARY OF PROVISIONS RELATING TO MENTALLY DISORDERED AND MENTALLY HANDICAPPED PERSONS

1. If an officer has any suspicion or is told in good faith that a person of any age, whether or not in custody, may be suffering from mental disorder or mentally handicapped, or cannot understand the significance of questions put to him or his replies, then he shall be treated as a mentally disordered or mentally handicapped person. [See *paragraph 1.4*]

2. In the case of a person who is mentally disordered or mentally handicapped, 'the appropriate adult' means:

- (a) a relative, guardian or some other person responsible for his care or custody;
- (b) someone who has experience of dealing with mentally disordered or mentally handicapped persons but is not a police officer or employed by the police; or
- (c) failing either of the above, some other responsible adult aged 18 or over who is not a police officer or employed by the police.

[See *paragraph 1.7(b)*]

3. If the custody officer authorises the detention of a person who is mentally handicapped or is suffering from a mental disorder he must as soon as practicable inform the appropriate adult of the grounds for the person's detention and his whereabouts, and ask the adult to come to the police station to see the person. If the appropriate adult is already at the police station when information is given as required in paragraphs 3.1 to 3.4 the information must be given to the detained person in his presence. If the appropriate adult is not at the police station when the information is given then the information must be given to the detained person again in the presence of the appropriate adult once that person arrives. [See *paragraphs 3.9 and 3.11*]

4. If the appropriate adult, having been informed of the right to legal advice, considers that legal advice should be taken, the provisions of section 6 of the code apply as if the mentally disordered or mentally handicapped person had requested access to legal advice. [See *paragraph 3.13*]

5. If a person brought to a police station appears to be suffering from mental disorder or is incoherent other than through drunkenness alone, or if a detained person subsequently appears to be mentally disordered, the

custody officer must immediately call the police surgeon or, in urgent cases, send the person to hospital or call the nearest available medical practitioner. It is not intended that these provisions should delay the transfer of a person to a place of safety under section 136 of the Mental Health Act 1983 where that is applicable. Where an assessment under that Act is to take place at the police station, the custody officer has discretion not to call the police surgeon so long as he believes that the assessment by a registered medical practitioner can be undertaken without undue delay. [See *paragraph 9.2*]

6. It is imperative that a mentally disordered or mentally handicapped person who has been detained under section 136 of the Mental Health Act 1983 should be assessed as soon as possible. If that assessment is to take place at the police station, an approved social worker and a registered medical practitioner should be called to the police station as soon as possible in order to interview and examine the person. Once the person has been interviewed and examined and suitable arrangements have been made for his treatment or care, he can no longer be detained under section 136. The person should not be released until he has been seen by both the approved social worker and the registered medical practitioner. [See *paragraph 3.10*]

7. If a mentally disordered or mentally handicapped person is cautioned in the absence of the appropriate adult, the caution must be repeated in the adult's presence. [See *paragraph 10.6*]

8. A mentally disordered or mentally handicapped person must not be interviewed or asked to provide or sign a written statement in the absence of the appropriate adult unless an officer of the rank of superintendent or above considers that delay will involve an immediate risk of harm to persons or serious loss of or serious damage to property. Questioning in these circumstances may not continue in the absence of the appropriate adult once sufficient information to avert the risk has been obtained. A record shall be made of the grounds for any decision to begin an interview in these circumstances. [See *paragraph 11.14* and *Annex C*]

9. Where the appropriate adult is present at an interview, he should be informed that he is not expected to act simply as an observer; and also that the purposes of his presence are, first, to advise the person being interviewed and to observe whether or not the interview is being conducted properly and fairly, and, secondly, to facilitate communication with the person being interviewed. [See *paragraph 11.16*]

10. If the detention of a mentally disordered or mentally handicapped person is reviewed by a review officer or a superintendent, the appropriate adult must, if available at the time be given opportunity to make

representations to the officer about the need for continuing detention. [See paragraphs 15.1 and 15.2]

11. If the custody officer charges a mentally disordered or mentally handicapped person with an offence or takes such other action as is appropriate when there is sufficient evidence for a prosecution this must be done in the presence of the appropriate adult. The written notice embodying any charge must be given to the appropriate adult. [See paragraphs 16.1 to 16.3]

12. An intimate search of a mentally disordered or mentally handicapped person may take place only in the presence of the appropriate adult of the same sex, unless the person specifically requests the presence of a particular adult of the opposite sex. [See Annex A, paragraph 4]

Notes for Guidance

E1 In the case of persons who are mentally disordered or mentally handicapped, it may in certain circumstances be more satisfactory for all concerned if the appropriate adult is someone who has experience or training in their care rather than a relative lacking such qualifications. But if the person himself prefers a relative to a better qualified stranger his wishes should if practicable be respected. [See Note 1E]

E2 The purpose of the provision at paragraph 3.13 is to protect the rights of a mentally disordered or mentally handicapped person who does not understand the significance of what is being said to him. It is not intended that, if such a person wishes to exercise the right to legal advice, no action should be taken until the appropriate adult arrives. [See Note 3G]

E3 It is important to bear in mind that although persons who are mentally disordered or mentally handicapped are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information which is unreliable, misleading or self-incriminating. Special care should therefore always be exercised in questioning such a person, and the appropriate adult involved, if there is any doubt about a person's mental state or capacity. Because of the risk of unreliable evidence, it is important to obtain corroboration of any facts admitted whenever possible. [See Note 11B]

E4 Because of the risks referred to in Note E3, which the presence of the appropriate adult is intended to minimise, officers of superintendent rank or above should exercise their discretion to authorise the commencement of an interview in the adult's absence only in exceptional cases, where it is necessary to avert an immediate risk of serious harm. [See Annex C, sub-paragraph 1(b) and Note C1]

To: Regional Directors of Public Health
 Copy: Regional General Managers
 District General Managers
 District Directors of Public Health
 Special Health Authority General Managers
 Special Hospitals Service Authority Chief Executive
 NHS Trust Chief Executives
 Family Health Services Authority General Managers
 Directors of Social Services
 Directors of Housing
 Chief Officers of Probation
 Chief Officers of Police
 Clerks to the Justices

**NHS Management
 Executive**

Department of Health
 Richmond House
 79 Whitehall
 London SW1A 2NS
 Telephone 071-210 3000

EL(92)24

8 April 1992

Dear Colleague,

Assessment of need for services for mentally disordered offenders and patients with similar needs

1. It is already Government policy that each region needs to develop a range of services for patients with mental illness or learning disabilities who are also offenders, violent or difficult to place for other reasons. The importance of a stable base for such services was emphasised to general managers in EL(90)190 and EL(92)6.
2. The implementation of that policy is currently being examined by a joint Department of Health and Home Office review of health and social services for mentally disordered offenders and others requiring similar services.
3. The review Steering Committee recommended that:
 - Regional health authorities should, in conjunction with other agencies, ensure that there is a regular assessment of the needs of their residents for secure provision
4. Regional directors of public health are now asked to assess the need for such provision. The assessments should be produced with the involvement of relevant statutory and voluntary agencies, in particular local authority social services departments, as part of their responsibilities for assessing the care needs of their populations, and criminal justice agencies.
5. The attached annexes contain further explanation (Annex A) and a basic format for responses (Annexes B to E). Assessments should be completed by 29 May 1992, so that the results can inform the work of the review which is due to report in July 1992. Enquiries about this letter should be addressed to Miss C A Miller, Room 113, Wellington House, 133-155 Waterloo Road, London SE1 8UG, Tel: 071-972 4507.

Yours sincerely,

Diana Walford

Dr D Walford
 Director of Health Care/Medical Director

John Reed

Dr John Reed
 Senior Principal Medical Officer
 Chairman, DH/Home Office review

This letter will be cancelled on 31 March 1993.

Assessment of need for services for mentally disordered offenders and patients with similar needs

Background

1. It is Government policy¹ that each region needs to develop a comprehensive range of:

- accommodation
- services

for people who are mentally ill or have learning disabilities who are also:

- offenders
- violent
- difficult to place (for other reasons)

so that people needing in-patient treatment within districts or regions do not remain in:

- prison
- special hospital
- the community

2. A joint Department of Health and Home Office review of health and social services for mentally disordered offenders, chaired by Dr John Reed, Senior Principal Medical Officer at the Department of Health, has recommended that:

Regional health authorities should (in conjunction with other relevant agencies) ensure that there is a regular assessment of the needs of their residents for secure provision and of the non-secure hospital needs of mentally disordered offenders, updated annually. We further recommend that this process should start as soon as possible so that regional health authorities produce their first assessment of needs before the end of this review.

The assessments should include anticipated demand for places for patients from the region for:

- Special hospital provision;
- Medium secure provision;
- Local secure provision;
- Local non-secure provision.

The assessment should include consideration, at each level, of 'special needs groups', especially people with learning disabilities (mentally handicapped), people with psychopathic disorder and those in need of long term (over 2 years) treatment and care. It should also take account of the NHS input to community care programmes for mentally disordered offenders.²

3. The recommendation has been endorsed by Ministers and this has been announced in Parliament.

Purpose of assessment

4. The purposes of the initial assessment are:

- a. to enhance local coordinated planning between health and social services and criminal justice agencies;
- b. to promote local responsibility for special hospitals and regional secure units;
- c. to begin a move from national norms for secure psychiatric provision³ to an approach based on the needs of local populations and the resources of local agencies;
- d. To initiate a regular process by which the whole range of services needed for difficult to place and offender patients is assessed and kept under regular review. This should eventually become a joint regular review. This should eventually become a joint agency responsibility. The services covered include assessment and diversion services and general services providing care, treatment and rehabilitation.

Initial scope of assessment

5. The assessment should include the need for secure provision for all mentally disordered people, including those categories of patient at paragraph 2 above. No exclusions should be made on the basis of diagnostic category or expected duration of treatment, though the assessment should identify whether there is a requirement for separate provision for patients with different clinical needs.

6. This initial assessment is limited to the need for secure hospital provision and liaison arrangements with the criminal justice system. Comments are also invited about coordination of assessments with local authorities, given their responsibilities for assessing the care needs of their populations and for ensuring that they are met.

Future scope

7. In future years the assessments will need to become wider, by incorporating other services for difficult to place and offending patients with mental illness, learning disability and personality disorders. Research⁴ will also be needed to help determine the scale and nature of the challenge and the form which successful intervention, care and treatment is likely to take.

8. One of the most difficult areas for future assessments will be the need for day and community services, including supervised accommodation such as hostels and sheltered housing, for mentally disordered people who pass through the criminal justice system, but do not require hospital provision. They may find themselves inappropriately imprisoned, detained in hospital or revolving through hospital, prison and the community if suitable provision is not available. If information is already available in some quantified form about the level of met and unmet need for such services this should be submitted as additional information with responses to the main questionnaire.

9. The views of addressees, including copy addressees (who should address any comments through the regional directors of public health), are sought as to how the needs of mentally disordered offenders and others requiring similar services can be assessed in future years. Such services are the responsibility of a number of agencies, in particular health authorities, local authorities and probation services. Other agencies, especially those in the criminal justice system, also have an interest in ensuring that needs are being adequately assessed and met.

Consultation with other agencies

10. An important factor in the process is the need to consult with other agencies who may be involved in providing services for difficult to place or offender patients. Social services departments in particular have a complementary role in assessing the community care needs of their residents. These include:

- Special hospitals
- District health authorities
- Family health services authorities / GP fund holders
- Local authority social services and housing departments
- Prisons
- Probation
- Police
- Courts
- Relevant voluntary organisations

Definitions

11. For the purposes of this assessment:

a. *Maximum secure provision* means the special hospitals; namely Ashworth, Broadmoor and Rampton;

b. *Medium secure provision* means wards or units such as regional security units, usually organised on a regional health authority or sub-regional basis;

c. *Local secure provision* or *low security* means facilities, usually organised at district health authority level, such as intensive care or special care wards, or units offering care in conditions more secure than an open psychiatric ward with normal staffing levels.

d. *Suitable arrangements* for diversion from the criminal justice system means considered adequate by the relevant social services department and health authority as well as by police and probation authorities or the prisons service as appropriate. If the agencies disagree about the suitability of the arrangements, this should be stated in the response.

Additional information

12. Information about the place of residence of special hospital patients is available from the special hospitals service authority. A list of the distribution of special hospital patients by district health authority in January 1992 is enclosed for information at Annex F. In future years, the Department will consider whether additional information can be made available centrally about mentally disordered people in prison and in special hospitals. The Directorate of Prison Medical Services is currently compiling a list of names and addresses of prisoners who are thought to be mentally disordered. This will be sent to regional directors of public health as soon as it becomes available (hopefully in time to assist with this exercise).

Format

13. A basic format for responses is attached as Annexes B-E. If space provided is not adequate then, so long as the question numbers are retained responses can be provided in a different format. Equally, any additional information, for example about liaison arrangements with social services departments, or about services not yet included in the scope of the assessment, may be provided in any suitably concise form.

Time-Scale

14. The Steering Committee of the review of health and social services for mentally disordered offenders is due to report to Ministers in about July 1992. In order that the results of this initial needs assessment exercise can inform the work of the review, the exercise needs to be completed by the end of May.

Contacts

15. Special Hospitals:

Dr J Sylvester (Ashworth)
Mr M Thomas (Rampton)
Mrs C Hewington (Broadmoor)

Prison Service:

Mr J Greenland
Directorate of Prison Medical Services
Room 830
Cleland House
Page Street
London SW1P 4LN

Department of Health:

Miss C A Miller
Room 113
Wellington House
133-155, Waterloo Road
London SE1 8UG

1. Government response to the second report from the Social Services Committee, 1984-85 session. Cmnd 9673, London, HMSO, 1985.

2. Advice on the implementation of the 'care programme approach' was contained in Health Circular(90)23 and Local Authority Social Services Letter(90)11.

3. Health Services Circular (Interim Series) 61 in 1974 required the initial development of 20 secure places per million population. No reference was made to the relative needs of populations in different parts of the country such as rural and urban areas ensuring they are met. In future years the process is intended to evolve to include the need for non-secure provision for patients diverted from the criminal justice system and mentally disordered people released from prison. In order to ensure a national coverage, responses should relate to regional health authority boundaries on this occasion.

Maximum security (special hospitals)

1 How many patients from the region were in special hospital on 31 March 1992 (please specify which special hospital(s) they were in)?

2 a. Are the needs of the region likely to change over the next five years? Yes/No

If yes, approximately how many beds (it is appreciated that this cannot be a precise figure) are likely to be required on:

b. 31 March 1994.

c. 31 March 1997.

d. On what basis is this estimate made (e.g. change in local factors, change in other levels of hospital or community services)?

3. How many of the patients counted in the answer to B.1 are, in the opinion of the responsible medical officer, ready to move to less secure accommodation?

4. What is the average return travelling time (in quarterdays), assuming a case conference lasts one hour, from individual districts in the region to each of the special hospitals? (this will enable the Department to estimate the time and resource implications of attendance at annual case conferences by local health and social services for each patient from your region in maximum security)

a. Rampton

b. Ashworth

c. Broadmoor

5. Does the region have a waiting list of residents requiring maximum security (including those who may need long stay provision)? Yes/No

If yes, how many were on the waiting list on 31 March 1992?

6. Any other comments about maximum secure provision:

Medium security (e.g. regional secure units and equivalents including the independent sector)

1. How many patients from the region were in medium secure provision on 31 March 1992?
(including patients in hospitals outside the region)

2. a. Are the needs of the region likely to change over the next five years? Yes/No

If yes, approximately how many beds (it is appreciated that this cannot be a precise figure) are likely to be required on:

b. 31 March 1994.

c. 31 March 1997.

d. On what basis is this estimate made (e.g. change in local factors, change in other levels of hospital or community services)?

3. How many of the patients counted in the answer to C.1 are waiting for admission to more secure accommodation?

4. How many of the patients counted in the answer to C.1 are, in the opinion of the responsible medical officer, ready to move to less secure accommodation?

5. What is the average return travelling time (in quarterdays), assuming a case conference lasts one hour, from individual districts in the region to the locations where patients are being treated in conditions of medium security? (this will help the Department to estimate the time and resource implications of attendance at six-monthly case conferences by local health and social services for all patients in medium security).

6. Does the region have a waiting list for patients requiring medium security (including those who may need long stay provision)? Yes/No

If yes, how many were on the waiting list on 31 March 1992?

7. Any other comments about medium secure provision:

Low security (e.g local special/intensive care or equivalent, including the independent sector)

1. How many patients from the region were in low security on 31 March 1992? (including patients in hospitals outside the region)

2. a. Are the needs of the region likely to change over the next five years? Yes/No

If yes, approximately how many beds (it is appreciated that this cannot be a precise figure) are likely to be required on:

b. 31 March 1994.

c. 31 March 1997.

d. On what basis is this estimate made (e.g. change in local factors, change in other levels of hospital or community services)?

3. How many of the patients counted in the answer to D.1 are waiting for admission to more secure accommodation?

4. How many of the patients counted in the answer to D.1 are, in the opinion of the responsible medical officer, ready to move to less secure accommodation?

5. What is the average return travelling time (in quarterdays), assuming a case conference lasts one hour, from individual districts in the region to the locations where patients are being treated in conditions of low security? (this will help the Department to estimate the time and resource implications of attendance at monthly and pre-discharge case conferences by local health and social services for all patients in low security).

6. Does the region have a waiting list of residents requiring access to low security (including those who may need long stay provision)? Yes/No

If yes, how many were on the waiting list on 31 March 1992?

7. Any other comments about low security:

5. How many of the courts have a suitable, multi-disciplinary (health and social services) mental health assessment and diversion scheme to screen, identify and divert mentally disordered defendants?

6. Does the region expect to meet the need for suitable, multi-disciplinary (health and social services) mental health assessment and diversion schemes to screen, identify and divert mentally disordered defendants from courts in the region over the next five years? (other agencies will need to be consulted about their plans to make available elements of these services for which they are responsible)

7. How many prisons are there in the region?

8. How many of the prisons have a suitable multi-disciplinary mental health assessment and diversion scheme to screen, identify and divert mentally disordered offenders?

9. Does the region expect to meet the need for suitable multi-disciplinary mental health assessment and diversion schemes in prisons in the region to screen, identify and divert mentally disordered offenders over the next five years? (other agencies will need to be consulted about their plans to make available elements of these services for which they are responsible)

10. How many of the prisons have suitable multi-disciplinary arrangements for the parole and release into the community of mentally disordered inmates?

11. Does the region expect the need for suitable multi-disciplinary arrangements in prisons in the region for the parole and release into the community of mentally disordered inmates to be met over the next five years? (other agencies will need to be consulted about their plans to make available elements of these services for which they are responsible)

12. Any other comments about liaison with the criminal justice system:

Annex F to this letter is omitted



THE UNIVERSITY
OF BIRMINGHAM

Centre for Research and Information Into Mental Disability

RESEARCH REPORT No 1

MENTAL IMPAIRMENT IN THE WEST MIDLANDS

Introduction

The most common reasons for legal detention in a mental handicap hospital are that the patients suffers from a 'severe mental impairment' or a 'mental impairment'. The 1983 Mental Health Act defines 'severe mental impairment' as:

'A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'.

The definition of 'mental impairment' is similar, but begins as follows:

'A state of arrested or incomplete development of mind (not amounting to severe mental impairment)...

This legal distinction is hardly very clear, and it is customary to use the term 'mental impairment' to refer to the two groups taken as a whole.

The 1983 Mental Health Act provides two main routes to detention for patients with a mental impairment:

1. On the written recommendations of two registered medical practitioners, in cases where hospital treatment is likely to alleviate or prevent a deterioration of the condition and where it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained in hospital.
2. Where a court makes a 'hospital order' on a convicted prisoner who has committed an offence punishable with imprisonment in cases where the mental disorder is of a degree which makes it appropriate for him to be detained in hospital for medical treatment and where such treatment is likely to alleviate or prevent a deterioration in his condition. Crown courts may add a 'restriction

order' to the hospital order in cases where it is necessary to protect the public from serious harm. The restriction order may specify a minimum duration for detention, or may include no time limit for detention. Discharge from a restriction order can be made by a mental health review tribunal, with the approval of the Home Secretary.

In addition, a small number of mentally-handicapped people are detained under the 1964 Criminal Procedure (Insanity) Act, which includes provision for detaining people who are found unfit to plead.

Many health authorities have been slow to develop services for patients with a mental impairment. The Department of Health report Needs and Responses: Services for Adults with Mental Handicap who are Mentally-ill, who have Behaviour Problems, or who Offend (1989) found that limited services exist for this group, and that liaison between services is often ineffective. As a result, people with a learning disability have accumulated in special hospitals and are over-represented in the general prison population.

The pattern of services needed for people detained as 'mentally-impaired' was outlined in 1990 by the RHA in Strategy for the Development of Mental Impairment Services. This proposed a need for an integrated regional service providing treatment and rehabilitation for patients with a mental impairment, to ensure that people with a mental impairment would be treated under the Mental Health Act rather than in prison. The RHA proposed that this service should include medium-secure units, half-way houses to provide a phased transition from the medium-secure units to community residence; and long-term units to provide long-term treatment and rehabilitation for patients who do not need a high degree of security. The first part of this service to be in place is a 12-bed medium secure unit (the 'Janet Shaw Clinic') at Chelmsley Hospital.

In order to plan these services, it is necessary to find out the numbers and characteristics of people with a learning disability who have either been detained in hospital as mentally-impaired, or who have been committed to prison. There have been some studies of specialist hospital units in other regions, but little is known about this group of patients in the West Midlands Region or the kind of services needed for them. This report outlines the results from a research project to identify all patients from the region who are detained as mentally impaired in either a mental hospital or a special hospital.

Method

Consultant psychiatrists in all mental handicap and mental illness hospitals in the West Midlands Health Region and in the special hospitals were asked to send details of patients admitted from home addresses in the region, who were currently detained as

'mentally-impaired' or 'severely mentally-impaired' under the 1983 Mental Health Act, plus mentally-handicapped people detained under the 1964 Criminal Procedure (Insanity) Act. All consultants co-operated with the study. Data was collected from medical casenotes.

Results

55 patients were identified, comprising 15 who were detained as 'severely mentally-impaired', and 40 as 'mentally-impaired'. Fifteen of the patients were resident in special hospitals, 37 were in mental handicap hospitals, and three were on leave and living in the community. None were resident in mental illness hospitals. The 37 patients resident in mental handicap hospitals were in eight different hospitals in the region.

The great majority of the 55 patients were male, less than 40 years of age, and had mild mental handicap. This is summarised in the table below.

		Number
SEX	Male	47
	Female	8
AGE	Under 21	5
	21 - 40	38
	41 and above	12
MENTAL HANDICAP	Mild	41
	Moderate	9
	Severe	5
MENTAL ILLNESS	Current psychosis	11
	Past history	6
	No record	38

A substantial minority of the patients (22) had criminal convictions (mainly violent and/or sexual offences), while a total of 27 had records of aggressive behaviour, 20 had sexual problems, and seven had records of arson. Eleven patients had a current psychosis, and a further six had histories of mental illness. There was no consistent difference between patients detained as 'mentally-impaired' and those detained as 'severely mentally-impaired'. The latter term seems to be used in some cases to designate patients with severe mental handicap, and in other cases for patients with a mild mental handicap who have severe behaviour disorders.

Most of the patients had been resident in hospital for prolonged periods, and 33 had been inpatients for a continuous period of six or more years. Despite this, staff assessments indicated that at least 11 of the patients could be placed in a hostel or home in the community. However, at least 14 needed to be in locked facilities with high levels of supervision (of whom six needed to be in a high security unit), and 21 needed close supervision in an unlocked facility. Staff assessments of the most appropriate placement were unavailable for nine of the patients.

Conclusions

The survey indicates that people detained as 'mentally-impaired' constitute about 1/100,000 population in the West Midlands Region. However, this is likely to be an underestimate of the true number of patients who need a specialised service because the lack of such a service makes courts reluctant to use hospital orders in place of imprisonment. The survey also confirms that many of the patients detained in either special hospitals or mental handicap hospitals could be resettled in less secure accommodation if an integrated service existed. It is necessary to look at the needs of this group of patients in more detail, and to evaluate the services they currently receive.

References

The research summarised in this report is from the following paper, which has been accepted for publication by Medicine, Science, and the Law:

DJ Clarke, J Beasley, JA Corbett, VHR Krishnan, and S Cumella (1991).
Mental Impairment in the West Midlands.

Research report by Stuart Cumella and David Clarke, June 1991.



DEPARTMENT OF HEALTH

JOINT HEALTH/SOCIAL SERVICES CIRCULAR

HEALTH AND SOCIAL SERVICES DEVELOPMENT "CARING FOR PEOPLE"

THE CARE PROGRAMME APPROACH FOR PEOPLE WITH A MENTAL ILLNESS REFERRED TO THE SPECIALIST PSYCHIATRIC SERVICES

This Circular will be cancelled on 10 September 1995

SUMMARY

This circular:

- I. requires district health authorities, the Bethlem and Maudsley Special Health Authority and the Special Hospitals Service Authority to implement the care programme approach envisaged in HC(88)43 (Appendix 4, paragraph 3) for people with a mental illness, including dementia, whatever its cause, referred to the specialist psychiatric services;
- II. asks social services authorities to collaborate with health authorities in introducing this approach and, as resources allow, to continue to expand social care services to patients being treated in the community.

It builds on the general circular on hospital discharges (HC(89)5). The Annex to this circular sets out:-

- I. the policy background to the care programme approach;
- II. how the care programme approach works;

and draws attention to some specific matters which will need to be addressed in establishing care programmes.

ACTION

By 1 April 1991 District health authorities and the Bethlem and Maudsley Special Health Authority must have drawn up and implemented, in consultation and agreement with social services authorities, local care programme policies to apply to all in-patients considered for discharge, and all new patients accepted, by the specialist psychiatric services they manage from that date. Where a district health authority purchases psychiatric services from a self-governing trust or elsewhere, the contractual arrangements should require these organisations to have adopted the care programme approach.

By 30 April 1991 Regional health authorities must confirm to the NHS Management Executive (via their Regional Liaison Principal) that all district health authorities in their areas have introduced the care programme approach.

By 30 April 1991 The Bethlem and Maudsley Special Health Authority must confirm (via its Regional Liaison Principal) that it has introduced the care programme approach.

Special Hospitals The requirements set out in this circular also apply to the Special Hospitals under the management of the Special Hospitals Service Authority. The SHSA will need to ensure that action has been taken to provide for the introduction of the care programme approach and should have received confirmation to that effect from each Special Hospital by 30 April 1991. In particular the SHSA will want to ensure that each patient's care plan enables any transfers to NHS or local authority social services facilities required by particular patients to be identified and arranged in good time.

RESOURCES

1. Health authorities are expected to meet any health service costs arising from the introduction of more systematic procedures from existing resources. Introducing the care programme approach places no new requirement to provide services on either health or social service authorities.
2. Health authorities will judge what resources they make available for such services. Social services authorities will make similar decisions but will have available specially targetted resources through the new specific grant which is to be used in ways agreed with relevant DHA(s). (Details of the new grant, payable from 1991/2, are set out in HC(90)24/LAC(90)10.

ENQUIRIES

3. Enquiries about this circular should be addressed to Mr G Payne, PHS3, Department of Health, Alexander Fleming House, London SE1 6BY.

This circular may be freely reproduced by those whom it is addressed.

Limited numbers of copies may also be obtained from the Department of Health Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancashire OL10 2PZ, quoting the code and serial number appearing at the top right hand corner of the front sheet.

ANNEX

THE CARE PROGRAMME APPROACH FOR PEOPLE WITH A MENTAL ILLNESS REFERRED TO THE SPECIALIST PSYCHIATRIC SERVICES

Introduction

1. This Annex sets out:

- a. the policy background to the care programme approach;
- b. how the care programme approach works;

and gives guidance on some key issues to be addressed in implementation.

Policy Background

2. The 1975 White Paper "Better Services for the Mentally Ill" (Cmnd 6233) first set the general policy within which care programmes should be introduced: this general policy has been endorsed by the Government in the 1989 White Paper "Caring for People" (Cm 849), paragraph 7.4. Locally-based hospital and community health services, co-ordinated with services provided by social services authorities, voluntary and private sectors, and carers, can provide better care and treatment for many people with a mental illness than traditional specialist psychiatric hospitals.

3. Community based services are only an improvement when the patients who would otherwise have been hospital in-patients get satisfactory health care, and, where appropriate, social care. "Caring for People" acknowledged that providing adequate arrangements for the community care and treatment of some patients had proved more difficult and resource intensive than expected. In practice adequate arrangements have not always been achieved.

4. The care programme approach is being developed to seek to ensure that in future patients treated in the community receive the health and social care they need, by:

- i. Introducing more systematic arrangements for deciding whether a patient referred to the specialist psychiatric services can, in the light of available resources and the views of the patient and, where appropriate, his/her carers, realistically be treated in the community;
- ii. ensuring proper arrangements are then made, and continue to be made, for the continuing health and social care of those patients who can be treated in the community.

How the Care Programme Approach Works

5. Individual health authorities, in discussion with relevant social services authorities, will agree the exact form the care programme approach will take locally. All care programmes should, however, include the following key elements:

- i. systematic arrangements for assessing the health care needs of patients who could, potentially, be treated in the community, and for regularly reviewing the health care needs of those being treatment in the community;
- ii. systematic arrangements, agreed with appropriate social services authorities, for assessing and regularly reviewing what social care such patients need to give them the opportunity of benefitting from treatment in the community;
- iii. effective systems for ensuring that agreed health and, where necessary, social care services are provided to those patients who can be treated in the community.

6. It will be for relevant health and social services staff to decide whether the resources available to them can enable acceptable arrangements to be made for treating specific patients in the community. If a patient's minimum needs for treatment in the community - both in terms of continuing health care and any necessary social care - cannot be met, in-patient treatment should be offered or continued, although (except for patients detained under the Mental Health Act) it is for individual patients to decide whether to accept treatment as an in-patient. Health authorities will need to ensure that any reduction in the number of hospital beds does not outpace the development of alternative community services.

Implementation

7. Within the broad framework described it is for health authorities, in discussion with consultant psychiatrists, nurses, social workers and other professional staff, and social services authorities to seek to establish suitable local arrangements, and to see that they are maintained in the context of purchaser/provider arrangements post 1 April 1991.

8. There are some specific issues which all authorities will however need to address in determining their local arrangements. These relate to:

- Inter-professional working;
- Involving patients and carers;
- Keeping in touch with patients and ensuring agreed services are provided;
- the role of key workers.

Inter-professional working

9. Although all the patients concerned will be patients of a consultant psychiatrist, modern psychiatric practice calls for effective inter-professional collaboration between psychiatrists, nurses, psychologists, occupational therapists and other health service professional staff; social workers employed by social services authorities, and general practitioners and the primary care team, and proper consultation with patients and their carers.

10. Where it is clear to a consultant and professional colleagues that continuing health and/or social care is necessary for a patient whom they propose to treat in the community, there must be proper arrangements for determining whether the services assessed as necessary can, within available resources, be provided. It is essential to obtain the agreement of all professional staff and carers (see paragraphs 12 and 13 below) expected to contribute to a patient's care programme that they are able to participate as planned.

Involving patients

11. It is important that proper opportunities are provided for patients themselves to take part in discussions about their proposed care programmes, so that they have the chance to discuss different treatment possibilities and agree the programme to be implemented.

Involving carers

12. Relatives and other carers often know a great deal about the patient's earlier life, previous interests, abilities and contacts and may have personal experience of the course of his/her illness spanning many years. Wherever consistent with the patient's wishes, professional staff should seek to involve them in the planning and subsequent oversight of community care and treatment.

13. Carers often make a major and valued contribution to the support received by many people with a mental illness being treated in the community. Where a care programme depends on such a contribution, it should be agreed in advance with the carer who should be properly advised both about such aspects of the patient's condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day-to-day basis. In addition, professional staff may be able to offer the carer help in coming to terms with his/her role vis-a-vis the patient.

Arrangements for keeping in touch with patients and making sure the services agreed as part of the programme are provided

14. Once an assessment has been made of the continuing health and social care needs to be met if a patient is to be treated in the community, and all the professional staff expected to contribute to its implementation have agreed that it is realistic for them to make the required contributions, it is necessary to have effective arrangements both for monitoring that the agreed services are, indeed, provided, and for keeping in contact with the patient and drawing attention to changes in his or her condition. This is a narrower concept than that of case management as envisaged in the White Paper "Caring for People" and upon which specific guidance will shortly be given to local authorities. In the Department's view the most effective means of undertaking this work is through named individuals, often called key workers, identified to carry the responsibilities outlined above in respect of individual patients.

15. **Key workers.** Where this can be agreed between a health authority and the relevant social services authority, the ideal is for one named person to be appointed as key worker to keep in close touch with the patient and to monitor that the agreed health and social care is given. The key worker can come from any discipline but should be sufficiently experienced to command the confidence of colleagues from other disciplines. When the key worker is unavailable, proper arrangements should be made for an alternative point of contact for the patient and any carer(s).

16. A particular responsibility of the key worker is to maintain sufficient contact with the patient to advise professional colleagues of changes in circumstances which might require review and modification of the care programme.

17. In addition to key worker arrangements, professional staff implementing a care programme may decide that they need a suitable information system as a means of keeping in touch and prompting action. Systems using a micro-computer are available and some relevant information about them is available from Research and Development for Psychiatry, 134 Borough High Street, London, SE1 1LB, Tel: 071-403-8790. When establishing such a system, those concerned have a duty to consider how to ensure the proper confidentiality of information about individual patients.

18. Sometimes patients being treated in the community will decline to co-operate with the agreed care programmes, for example by missing out-patient appointments. An informal patient is free to discharge himself/herself from patient status at any time, but often treatment may be missed due to the effects of the illness itself, and with limited understanding of the likely consequence.

19. Every reasonable effort should be made to maintain contact with the patient and, where appropriate, his/her carers, to find out what is happening, to seek to sustain the therapeutic relationship and, if this is not possible, to try to ensure that the patient and carer knows how to make contact with his/her key worker or the other professional staff involved. It is particularly important that the patient's general practitioner is kept fully informed of a patient's situation and especially of his or her withdrawal (partial or complete, see paragraph 20 below) from a care programme. The general practitioner will continue to have responsibility for the patient's general medical care if she/he withdraws from the care programme.

20. Often patients only wish to withdraw from part of a care programme and the programme should be sufficiently flexible to accept such a partial rather than a complete withdrawal. It is important that, within proper limits of confidentiality, social services day care, residential and domiciliary staff (including those from the voluntary and private sectors) are given sufficient information about the situation to enable them to fulfill completely their responsibility of care to the patient. Similarly, relatives and carers should also be kept properly informed.

Recommendations of the staffing and training advisory group

Part One

1. WE RECOMMEND that the Steering Committee considers how work on the staffing and training implications of services for mentally disordered offenders with "special needs" can best be carried forward.
2. WE RECOMMEND that our findings are used as a basis for initial planning, but that the results of objective local needs assessments, together with data obtained in due course from improved information and other systems, should be built into rolling projections of future staffing and training needs.
3. WE RECOMMEND that staffing requirements are determined locally to reflect the level and pattern of services indicated by needs assessments and quality requirements. They should not be calculated simply as a proportion of broad national estimates.

Part Two

4. WE RECOMMEND that the apparent discrepancies between Department of Health and Royal College of Psychiatrists staffing data are examined in the interests of seeking consistency in the future.
5. WE RECOMMEND that (as is already intended) information on the staffing of medium secure units is collected on a regular and consistent basis.
6. WE RECOMMEND that the adequacy of relevant targets for senior registrar and registrar numbers is considered in light of recommendations made by the current review.
7. WE RECOMMEND that Family Health Service Authorities ensure that their assessments of need and consequent planning of primary care services take account of mentally disordered offenders and the links that will be necessary with other

agencies.

8. WE RECOMMEND that the Department of Health considers the need for more comprehensive data on the staffing of social services for mentally disordered offenders (and, where appropriate, general mental illness and learning disability services).

Part Three: Future Staffing Implications

Medical (paragraphs 3.14-3.36)

9. WE RECOMMEND that increases in general adult and forensic consultant psychiatrists are preceded by an expansion in senior registrar and registrar numbers, matched by increases in other disciplines contributing to multi-disciplinary work.
10. WE RECOMMEND that, as a preliminary to the expansion of consultant posts recommended in this report, Regional Health Authorities fund as soon as possible the unfilled senior registrar posts in forensic and, where appropriate, general psychiatry that have agreed by the Joint Planning Advisory Committee.
11. WE RECOMMEND that consideration is given by the Department of Health, the Health Care Service for Prisoners, the Royal College of Psychiatrists and the Joint Planning Advisory Committee to our initial estimate that, over the next 5-10 years, some 80 new consultant forensic psychiatrist posts and 175 other consultant posts may be needed to meet the expanding clinical needs of services for mentally disordered offenders. They should consider also what uplift will be necessary to take account of factors such as audit, monitoring, evaluation, training and academic work, as well services for "special needs" groups.
12. WE RECOMMEND that (in conjunction with the above) consideration is given to the number of registrar and senior registrar posts that will be required to ensure that there are sufficiently qualified doctors to fill and, in future years, maintain the increased number of consultant posts.

Prison staff (3.24-3.31)

13. WE RECOMMEND that staff working with mentally disordered offenders (in prison or elsewhere) should be encouraged to report to their managers any problems which hinder their effective delivery of patient care. They should also be able to feel confident that such reports will be taken seriously and that, where necessary and possible, remedial action will be taken.

14. WE RECOMMEND that contributions to Suicide Prevention Management Groups are sought from a range of health, social and probation services staff as a matter of course. (This supplements the recommendation at paragraph 6.19 of the report of the prison advisory group).

Nursing (3.37-3.42)

15. WE RECOMMEND that employing authorities, in conjunction with schools of nursing, consider the implications for nurse staffing and training of the proposed increases in medium secure beds. There should also be joint planning between these bodies and local prisons to ensure that the future specialised needs of prisoners can be met.

Therapists (3.47)

16. WE RECOMMEND that medium secure units should have the financial flexibility to purchase therapy services directly if these cannot otherwise be secured.
17. WE RECOMMEND that early priority is given to expanding therapy services based in Special Hospitals and medium secure units and that agencies generally give active consideration to the role of therapists working with mentally disordered offenders so that their future involvement in such services can be planned more effectively.

Social and probation services (3.48-3.61; 3.63-3.68)

18. WE RECOMMEND that services for mentally disordered offenders form part of local authorities' community care plans for 1993/4.
19. WE RECOMMEND that local authorities consider designating a senior officer to be responsible for the overall development of work with mentally disordered offenders.
20. WE RECOMMEND that social and probation services establish mechanisms for closer working in identifying the accommodation and support needs of mentally disordered offenders.
21. WE RECOMMEND that probation officers are part of mental health care teams contracted in to prisons.
22. WE RECOMMEND that consideration is given to seconding probation officers for work in medium secure units.

Education (3.69-3.72)

23. **WE RECOMMEND** that medium secure units should have the financial flexibility to purchase education services directly if these cannot otherwise be secured.

Part Four: Training and Education Needs

24. **WE RECOMMEND** that training for work with mentally disordered offenders is reflected in the plans of all relevant agencies and that, as far as possible, these should be based on joint or complementary approaches. Action locally should be matched by a coordinated approach to training issues at national level.

Medical (4.6-4.23)

25. **WE RECOMMEND** that consultant posts with a special interest in forensic psychiatry are retained for the time being, but that their existence is kept under review.
26. **WE RECOMMEND** that all specialised forensic psychiatric training includes an academic component.
27. **WE RECOMMEND** that forensic psychiatry is covered in the Royal College of Psychiatrists' forthcoming guidance on the continuing education of consultants.
28. **WE RECOMMEND** that forensic issues are covered in general psychiatric training for medical students.
29. **WE RECOMMEND** that Regional forensic advisers are responsible, in consultation with other forensic psychiatrists, for ensuring that optimum medical training opportunities in forensic settings are available at both basic and post-qualifying levels.
30. **WE RECOMMEND** that options for improving effective working between forensic and general psychiatry, and other psychiatric specialties, are explored and, where possible, developed.
31. **WE RECOMMEND** that an early induction course should be mandatory for doctors working regularly in the Prison Health Care Service. This should be designed to familiarise them with range of clinical, legal and operational issues.
32. **WE RECOMMEND** that staff grade or consultant psychiatrists should undertake a specialised post-induction course.
33. **WE RECOMMEND** that training opportunities for psychotherapy with mentally disordered offenders should be increased and that the development of such training should be based initially on units which currently have psychotherapists working with these or similar patients.

Nursing (4.24-4.36)

34. **WE RECOMMEND** that health authorities re-examine their training targets for psychiatric nurses in light of this review.
35. **WE RECOMMEND** that training courses for community psychiatric nurses include consideration of forensic nursing issues and opportunities for placements in forensic settings.
36. **WE RECOMMEND** that the English National Board considers the future need for Project 2000 training in forensic psychiatric nursing, including opportunities for suitable placements.
37. **WE RECOMMEND** that the English National Board continues to encourage the development of joint training schemes between the independent sector and the NHS.
38. **WE RECOMMEND** the speedy introduction of more flexible arrangements for, and content of, post-basic education and training in subjects related to forensic nursing, including greater opportunities for open learning and better links with further and higher education.
39. **WE RECOMMEND** that initiatives taken to enrol prison nurses on specialised ENB courses are maintained and developed.
40. **WE RECOMMEND** that prisons continue to forge closer links with local hospitals, colleges of nursing and others who can assist in the development of nurse education.

Psychology (4.37-4.40)

41. **WE RECOMMEND** that employing authorities give urgent consideration to the need for an increase in postgraduate training places for clinical psychologists to work with mentally disordered offenders.

Therapists (4.41-4.48)

42. **WE RECOMMEND** that consideration is given to the need for specialised post-qualifying training for occupational therapists working in secure settings.
43. **WE RECOMMEND** increased training opportunities for occupational therapy helpers and technical instructors working with mentally disordered offenders to attain professional status and generally to improve their skills.
44. **WE RECOMMEND** that the Department of Health and the College of Speech and Language Therapists give further consideration to the development of an advanced specialised course for speech therapists working in psychiatry. They should consider also the

scope for encouraging the development of speech therapy departments.

Social and probation services (4.49-4.61)

45. WE RECOMMEND that the Central Council for Education and Training in Social Work provides guidance on the particular skills required by social workers and probation officers involved in the care and management of mentally disordered offenders.
46. WE RECOMMEND that CCETSW considers the need for an additional specialised training module which addresses the skills and knowledge needed by social workers and probation officers working with mentally disordered offenders or similar patients in secure settings.
47. WE RECOMMEND that post-qualifying education and training is readily available for social services and probation staff working in a range of settings who are likely to come into contact with mentally disordered offenders.
48. WE RECOMMEND that revised guidance on the training and preparation of approved social workers should ensure that there is an adequate emphasis on the particular issues relating to mentally disordered offenders and on the working of the criminal justice system. There should also be training in the supervision provisions of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. Practice placements in forensic settings should be encouraged.
49. WE RECOMMEND that the Social Services Training Support Programme makes provision for the training of staff working with mentally disordered offenders.
50. WE RECOMMEND that the Department of Health and the Home Office should continue to encourage joint discussions between the probation and social work professions on their developing interface in work with mentally disordered offenders.

Criminal justice system (4.62-4.69)

51. WE RECOMMEND that police training should cover relevant aspects of the Mental Health Act 1983 and the initial identification of suspects who appear to be mentally disordered. There should also be opportunities for "refresher" training and joint training with other groups working with mentally disordered offenders.
52. WE RECOMMEND that the Home Office and Department of Health explore with the Lord Chancellor's Department, the Crown Prosecution Service and relevant professional and training bodies how training for court-based and legal staff who come into contact with mentally disordered offenders could best be promoted and made more widely available.

53. WE RECOMMEND that effective links are developed between local Law Societies and multi-agency groups for mentally disordered offenders.

Part Five: Multi-Agency Issues

Equal opportunities (5.3-5.7)

54. WE RECOMMEND that agencies' staffing and training policies adopt a positive approach to the special needs of women and people from ethnic minorities.

Multi-professional core teams (5.8-5.12)

55. WE RECOMMEND that agencies developing multi-professional core teams consider the scope for cross-membership with other relevant teams in the interests of overall service effectiveness.
56. WE RECOMMEND that the need to care for and treat mentally disordered offenders who are not referred to the specialised forensic (or other specialised) services should be reflected in the staffing and training of general mental health teams. (See also paragraph 3.8 of the report of the community advisory group.)
57. WE RECOMMEND that there should be closer links between teams caring for mentally disordered offenders and local social security offices to heighten understanding of the benefits system and to help ensure the prompt availability of benefit to those who qualify for it.
58. WE RECOMMEND that (in addition to the groups identified at paragraph 3.34 of the report of the community advisory group) core teams should include an identifiable prison link and that adult education, housing and employment services and a solicitor dealing with mentally disordered offender cases should be included as necessary.

Information (5.15-5.21)

59. WE RECOMMEND that comprehensive information on the use of section 136 of the Mental Health Act is collected in a standardised form so that satisfactory estimates can be made of the resource (including staffing and accommodation) implications of increased referrals to the health and social services. We support the view of the community advisory group that research is needed on the use of section 136 of the Mental Health Act 1983.

60. WE RECOMMEND that consideration is given to the development of systems which enable information that is likely to be needed, in a patient's interests, by practitioners in a range of agencies to be available across agency boundaries. These might operate under the aegis of strategic multi-agency groups for mentally disordered offenders (possibly linked to area committees for the criminal justice system). Account should be taken of ethical and practical difficulties, as well as views expressed through consultation on this report.

Court diversion schemes (5.22-5.29)

61. WE RECOMMEND that any national view on preferred models for court-based assessment and diversion schemes should be taken only after the growing range of such schemes, and outcomes for patients, have been fully evaluated.
62. WE RECOMMEND that agencies proposing to establish court diversion schemes work jointly from the outset to secure the range of professional inputs that may be needed and to assess the potential resource (including staffing and training) implications of increased diversion to the health and social services.
63. WE RECOMMEND that broadly-based guidance is prepared, and issued centrally, on the roles and training needs of staff (including court officials and members of the legal profession) involved in court diversionary work.
64. WE RECOMMEND that the Department of Health and the Home Office consider, initially with the relevant professional bodies, the scope for formal training for staff involved in court diversion schemes. Such training should reflect the fact that schemes are part of a much broader service network and that they are a means to an end, not an end in themselves.

Care programmes (5.30-5.35)

65. WE RECOMMEND that health, social services and criminal justice agencies agree a joint approach to the staffing, training and financial aspects of operating care programmes for mentally disordered offenders, including for discharged prisoners with continuing mental health care needs. The Department of Health, in conjunction with the Home Office, should also consider the resource implications of what, in practice, would be an extension of the care programme arrangements and should consider issuing guidance to health, social service and criminal justice agencies on the application of care programmes to mentally disordered offenders.
66. WE RECOMMEND that contracts to provide mental health care services to prisons should recognise explicitly the need to

operate the care programme approach.

67. WE RECOMMEND that care programmes should be automatic for patients remitted to prison after mental health treatment in hospital.

Risk assessment (5.36-5.40)

68. WE RECOMMEND that, wherever possible, assessments of risk are undertaken on a multi-disciplinary basis and that follow-up should usually form part of a care programme. This issue should be covered in revised guidance on care programmes.
69. WE RECOMMEND that agencies develop and observe clear guidelines for risk assessment and that staff are trained accordingly.
70. WE RECOMMEND that all staff working with mentally disordered offenders and similar patients are made aware of relevant guidance on the identification and handling of potentially dangerous or suicidal patients and of procedures for dealing with violence or threats to staff. Wherever necessary, this should be backed-up by practical training.

Central referral points (5.40-5.43)

71. WE RECOMMEND that agencies planning to establish a central referral point for the entry of mentally disordered offenders to the health and social services should appraise carefully the need for such a facility and its likely remit. This should take account of staffing and training and other resource considerations, as well as existing referral arrangements and the pre-eminent need to ensure that placements are found speedily. A central point need not be the sole point of referral, especially if an effective central register is maintained.

Transport (5.44)

72. WE RECOMMEND that the Steering Committee considers the responsibilities of agencies to provide or fund suitable transport and escorts for mentally disordered offenders.

Extract from the Government's Response to the Social Services Committee (Cmnd 9674, 1985), Annex 2

14. *Other staff*—notably clinical psychologists, speech, occupational and physiotherapists—have an important role to play in mental handicap services. Demand for the services of such staff continues to outstrip supply. This is often due to the slow development of understanding both within and without the particular profession as to the value of their contribution to mental handicap services, resulting in low establishment levels which can be a discouragement to recruitment even at that level. Those concerned with their deployment need to consider how they can contribute most effectively to the services offered to mentally handicapped people. Scarce staff should not confine themselves to providing direct treatment for a limited number of clients, but should devise and communicate programmes that can be carried out by helpers and others—including relatives where appropriate—and participate in in-service staff training. For example, occupational therapy provides its services in this way, and in fact there are disproportionately greater numbers of helpers than qualified staff. However, direct contact between occupational therapist and patient is needed in primary and continuing assessments, in specific activities and techniques, and in devising and implementing new programmes and approaches. Specific assessments (for example, for wheelchairs) also need qualified time. It is important therefore that the proportion of qualified to helper time is carefully considered in the light of local needs. All staff working with mentally handicapped people may find it helpful to have further in-service training, focussed on specific needs, to broaden their horizons and develop flexibility in the allocations of tasks between disciplines. To provide effective services in hospitals and in the community, therapists, clinical psychologists and nurses need to work closely together. Shared training programmes should help increase understanding of each other's contribution and an increased sharing of knowledge and skills should avoid unnecessary areas of overlap and gaps in service provision.

15. Health authorities also need to consider, with the relevant local authorities, the availability of social services staff to people in health service care. Particularly important will be access to social work help for patients and their families. Individual local authorities will make different arrangements but it is crucial that the system enables the social worker, whether based in hospital or in an area team, to act as a bridge between provision and services in the hospital and family and community resources outside. For those patients who also have a physical handicap and are living at home or moving into the community, there may be additional difficulties of independent functioning created by the physical environment. Most social services departments now employ occupational therapists specialising in assessment for and prescription of aids and teaching their use. Along with officers of housing departments and local authority grant officers, they are also involved extensively in the adaptation of properties to meet the needs of handicapped people. In order to enhance the movement of handicapped people into the community, there has to be close liaison between DHA officers and these therapists.

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CHASAC TEAM

(Community & Home Advisory Service
for Children with Autism and/or Challenging Behaviours)

Tel: 0734 566008

6 Pendragon Court
Southcote Lane
Reading
Berks
RG3 3AW

Information SheetWho are we?

We are a multidisciplinary health service team consisting of: two psychologists, two speech therapists, one occupational therapist and the team leader. We also have the services of a part-time secretary at our base.

What do we do?

We provide a home and community based assessment, treatment and support service to children with a wide variety of disabilities and handicaps. Children with autism and/or challenging behaviours are our primary focus although we do not operate very strict criteria for offering help.

Because the funding is from West Berkshire Health Authority our main efforts are in the area from Wokingham and Henley in the East to Hungerford and Lambourn in the West. We do accept referrals from other areas but these have to be paid for by either the child's G.P. (if fund-holding) or by their Health Authority.

We were started because of closure of the Health Authority's residential facility for children (Smith Hospital). Our aim is to enable families and children to live together more happily. We do not feel that it is possible for all families to live in the same house at all times, so we help families to find alternatives if that is what they wish to do. Above all we wish to work in partnership with parents and carers.

How do we operate?

When children are first referred, we allocate the case to a particular member of the team for a thorough assessment of their skills and needs. We also look carefully at the home setting and ask parents and other concerned individuals for their opinions. On the basis of that initial assessment we plan interventions which range from supporting and counselling family members to the provision of intensive therapeutic interventions with the child and family members. We also work closely with other agencies such as Community Mental Handicap Teams and Child Assessment Centres and Educational Agencies.

Staff: Tim Williams (Team Leader); Pam Chaplin, (Occupational Therapist); Andrea Howard, Mary-Jane Stroud (Psychologists); Harvey Sheppard (Child Psychiatrist); Anne Hopton, Elaine Crouch (Speech/Language Therapists); Aeryl Goodspeed (Secretary).

From our different professional perspectives we aim to work together to help the family understand the pattern of strengths and weaknesses in their child. We help them to manage difficult behaviour, to improve interaction and communication between their child and other people, and to provide an environment which will develop the full potential of the child. In general we work with and through the family, teaching them specific techniques where necessary. Sometimes more direct individual work with the child may be appropriate. For some older and more able children we run groups concentrating on social understanding and getting on with people. We are flexible in our approach, and try to provide whatever is needed in a particular case.

Evaluation and Research

Only a little is known about the treatment of autism and a bit more about the treatment of challenging behaviours. Therefore evaluation and research have been written into the operational policy. We are already collaborating with Reading University in a number of areas, such as the best method of teaching autistic children social skills, and we are now setting up a project with the Institute of Psychiatry in London to identify the factors maintaining challenging behaviours and hopefully to provide methods of treatment that are more efficient and effective than those used routinely at the moment.

How to refer

Referrals, preferably in writing, may be made through any member of the team. Most referrals come from Consultant Paediatricians or Senior Clinical Medical Officers although there is an open referral system. We will automatically contact the child's G.P. unless there are particular reasons for not doing so. We aim to see children within 8 weeks of the referral being made.

For further information please contact any of the team members listed below.

chasinfo.pro November 1991

Staff: Tim Williams (Team Leader); Pam Chaplin, (Occupational Therapist); Andrea Howard, Mary-Jane Stroud (Psychologists); Harvey Sheppard (Child Psychiatrist); Anne Hopton, Elaine Crouch (Speech/Language Therapists); Avryl Goodspeed (Secretary).

Offending by Individuals with AutismIntroduction:

Autism is a pervasive developmental disorder that occurs at a rate of around 3 - 4 per 10,000 and affects males much more commonly than females (with a ratio of approximately 4 to 1). The disorder affects the development and understanding of communication skills (both verbal and non-verbal development of social understanding (in particular social reciprocity and empathy). In addition autism is associated with obsessional behaviours, rituals and routines and a marked resistance to change. The majority of individuals with autism also suffer from severe learning difficulties and because of this will require specialist, often residential provision throughout life. A minority (about 20%) of individuals with autism, however, are of normal intelligence and it is this group in particular who tend to receive very little in the way of specialised support and for whom the understanding of their difficulties is often minimal. It is in this group that most incidences of offending probably occur.

There are no official figures for rates of offending by individuals with autism, probably because in many instances no diagnosis has been made. On the whole rates of offending in this group are probably very low, but because of the nature of the deficit, if criminal acts are committed, it can be very difficult to provide the offender with the care or understanding that is necessary to avoid future offences. The types of offences committed by individuals with autism fall into four main categories.

- 1) Cases where the autistic individual, because of his or her social naivety, is deliberately led into criminal acts by others.
- 2) Aggressive behaviours resulting from the disruption of routines or changes in daily circumstances.
- 3) Asocial behaviours related to a general lack of understanding, or in particular a misunderstanding of social cues.
- 4) Anti-social behaviours resulting from obsessional tendencies.
- 1) Crimes resulting from social naivety:

Because autistic people have an innate inability to see the world through other people's point of view (that is they seem to be lacking in the theory of mind) they are often totally naive when it comes to appreciating the motives of others. In particular, often being scrupulously honest and adhering strictly to rules themselves, they may be quite unable to understand deception of any kind. Moreover, because their social difficulties tend to result in their being lonely and isolated, if approaches are made by their peers these are greatly appreciated. In a number of cases this has led to unscrupulous individuals taking advantage of the "simplicity" of people with autism and using them as unwitting partners in crime. For example, one young man was taken up by a gang of local petty criminals who stole regularly from video shops. They would ask the autistic person to go into the shop and take a selection of tapes, promising that they would pay the shop owner later. If he succeeded the gang then made off with the tapes; if caught it was he who

got into trouble whilst they made their escape. A similar example is the case of a man who had worked in a jewellers shop for many years, and because there was no doubt about his own honesty was trusted with the keys to lock up each night. A new night watchman, quickly realising his vulnerability, easily persuaded him to relinquish the keys and was thereby able to remove large quantities of jewels with ease.

2) Aggressive behaviours resulting from disruption of routines:

Although severe aggression is not normally a trait particularly associated with autism, some individuals can become extremely agitated, and perhaps lash out indiscriminately if their routines are disrupted or if unpredicted changes occur. This has led on a number of occasions to the police being called when individuals have become extremely distraught following the cancellation of a train or buses not running on time etc. Their noisy and agitated behaviours, although rarely directed specifically at passers by, can be very frightening and certainly misinterpreted as potentially threatening. Another example is of a young, generally very peaceable young man, who attacked a cloakroom attendant because he was given the wrong coat. The lack of understanding of why or how such relatively trivial disruptions can occur leads to marked distress, which, because of the autistic person's inability to convey their feelings in a normal way, results in physical demonstrations of anger and anxiety. Unfortunately because they tend to view the "fault" in such situations to lie with the people or systems who have produced these changes in their routine, they may find it very difficult to understand that their own behaviour is unacceptable and may go to great lengths to justify this, often showing little or no remorse.

3) Behaviours related to lack of understanding or misinterpretation of social cues:

Because of their failure to understand much of what is going on around them, unless this is very carefully explained in detail, unprovoked aggression may sometimes occur if individuals with autism are placed in situations where they simply cannot cope with the level of social or other demands that are placed on them. Most autistic people, too, have problems not only with language but with understanding non-verbal cues. Facial expressions may be particularly difficult for them to interpret and they may, for example, presume that because someone is frowning - being critical, that this is aimed directly at them, despite other contextual cues to the contrary. This can, in rare instances, lead to attacks on people who they feel are looking at them or otherwise reacting in an aggressive or critical way.

Conversely their own facial expression can give misleading messages to strangers. In one or two cases young men with autism (having been taught at an early age that they must smile and make eye contact with people they meet) have been led, unknowingly into homosexual contacts. In other cases inappropriate smiles or approaches have led to their being accused of making unwanted sexual advances to people with whom they work or with whom they come into contact in other situations.

4) Anti-social behaviours resulting from obsessional tendencies:

This is perhaps the most difficult set of behaviours to deal with as the obsessional tendencies that are characteristic of autism are often extremely powerful and can come totally to dominate an individual's lifestyle.

Moreover, their failure to appreciate the dangerousness or other implications of these behaviours can result in a total lack of remorse and little desire to change their behaviours in future, even when their actions have had disastrous results. A fascination with particular topics is very common in autism and on occasions when obsessional interests have focused on potentially dangerous topics such as poisons, weapons or fire, other people's lives have been put at risk. In particular the fascination with fire has led to serious accidents in some cases. Another example of the way in which obsessions can lead to criminal activities, is that of a teenager obsessed with travel. Finding that he could easily copy his father's signature on cheques, he used the money from these to fund his extensive journeys around the country. Although he would never have taken money as such he did not perceive that the use of cheques in this way was at all dishonest and was totally unable to appreciate how unacceptable this was. Subsequently he went on to open more and more bank and building society accounts in different names and by the age of 16 had amassed a debt of several thousand pounds.

Over strict adherence to rules can also lead to problems. One young man for example is constantly getting into trouble whilst travelling on London tubes. He will insist on telling passengers to stop smoking or take their feet off seats etc. and if they refuse, as they usually do, he will physically try to prevent their infringement of these rules. This has led to his being attacked on several occasions or, alternatively being accused of assault himself.

Again, failure to predict the outcome of their actions, or to appreciate the potential dangers involved means that the individuals concerned make little or not attempt to change their behaviours or to avoid similar difficulties occurring in the future.

It must be said that in many cases the police have acted with considerable tact and understanding when faced with individuals with autism and frequently they do not press charges. However there are cases when the behaviours are so dangerous, and when the perception of the implications of their actions is so poor that confinement is necessary. Even in special prisons understanding of conditions such as autism is likely to be very limited and within the regular prison system there is likely to be no knowledge of the nature of autism, nor of the best ways of dealing with those suffering from this condition. In particular their apparent lack of remorse may result in unduly harsh treatment, especially when this is coupled with their marked impairments in social skills and their ability to form social relationships. Adequate diagnostic and assessment services for people with autism, particularly those who are of normal I.Q. and whose deficits may be much more subtle than those shown by more severely handicapped individuals are essential. The provision of practical advice to schools and families at an early age is also required if potentially dangerous or criminal activities are not to develop from interests, obsessions or routines that are initially quite innocuous in appearance. If offences do occur, the advice of special psychiatric or psychological services needs to be sought in determining both the risks of such behaviours occurring again and in advising about the most appropriate forms of treatment.

Dr Patricia Howlin
Institute of Psychiatry

Health services for people with learning disabilities (mental handicap)

Executive summary

People with learning disabilities (mental handicap) have the same rights of access to NHS services as everyone else but they may require assistance to use the services. Special care must be taken to ensure that they are not denied health care because of their disability, and that steps are taken to ensure that any barriers to access are minimized. Purchasing authorities should include in their contracts specific provision to enable people with learning disabilities to obtain NHS health care services and to ensure, where necessary, that special provision is made where the health care needs of people with learning disabilities cannot be met through the ordinary range of services.

Action

Purchasers should:

- ensure that service specifications for health care include appropriate provision for meeting the needs and promoting the health and wellbeing of people with learning disabilities;
- use contracts with provider units to ensure that wherever possible people with learning disabilities are enabled to use ordinary health services;
- consider contracting for additional services for people with learning disabilities, including:
 - i. alternatives to the ordinary services
 - ii. specialist assessment and treatment services
- Wherever possible contract to provide continuity of care and contact; taking into consideration the preference of the patient and his carers.

Additionally DHAs should:

- consider contracting for residential and respite care(annex A).
- ensure that during the transition to community-based services, the improvement in the quality of care in specialist mental handicap hospitals at least matches general improvements in health provision.

HSG(92) 42

Health services for people with learning disabilities (mental handicap)

26 October 1992

Addressees

For Action:

Regional Health Authorities
District Health Authorities
Special Health Authorities
NHS Trusts
Family Health Services
Authorities

For Information:

Local Authorities
Social Services
Community Health Councils

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- ensure that people with learning disabilities have access to general medical and dental practitioner services and, in collaboration with District Health Authorities, access to the primary health care team and other community health services.

Background

There is no precise information available nationally about the number of people with learning disabilities, or the degree of those disabilities. The number may be growing, as advances in health care mean people with particular forms of disability have a greater life expectancy. This will result in a higher proportion of people with more profound or multiple handicaps and consequently higher levels of dependency. Also people with learning disabilities may manifest at an earlier age health problems associated with old age.

People with learning disabilities have the same rights of access to health services as everyone else. Many have greater health needs than other people. This makes it particularly important that they should have full access to health care regardless of their disabilities whether they live at home, in NHS, local authority or independent sector accommodation.

Many people with learning disabilities need, and can use, the ordinary range of health services. Some, however, need assistance or special consideration in order to use these services. Others may have needs that can only be met by the provision of services solely for people with learning disabilities.

NHS Responsibilities

HSG(92) 42

Annex A

Health Services for people
with Learning Disabilities
(Mental Handicap)

26 October 1992

Contracts for the ordinary range of health services

Examples of ways in which it can be difficult for people with learning disabilities to get the health care they need, or be treated satisfactorily, are described in annex B. Sometimes such difficulties can be overcome without additional resources, in other cases additional resources will be necessary to enable people with learning disabilities to use the services satisfactorily. Either way, purchasers should aim to ensure that service specifications for health care include provision for meeting the needs of people with learning disabilities and that wherever practicable, people with learning disabilities can use the ordinary range of health services.

Contracts for additional health services

Purchasers should also consider contracting for services to meet the health needs of people with learning disabilities that cannot be met through contracts for the ordinary range of services. Consideration should be given to the following possibilities:

alternatives to the ordinary services

- In some cases it may prove impossible for the general health needs of people with learning disabilities to be met by ordinary NHS services. For example, where local NHS dental practitioners are unable to treat patients with severe learning disabilities, district health and family health services authorities should arrange alternative services as described in circular HC (89) 2;

Specialist mental health provision

- Some people with learning disabilities need treatment for psychiatric illness or severe behaviour disturbance. If it is not possible adequately to meet these patients' needs within the general psychiatric services, specialist assessment and treatment services will be needed in hospital or community settings;

NHS residential care

- The large majority of people with learning disabilities not living with their families can be cared for in residential accommodation arranged through the relevant social services authority. There are, however, likely to be a small number of people with severe or profound learning disabilities and physical, sensory or psychiatric conditions who need long term residential care in a health setting. Where this seems to be the case a multi-professional assessment and consultation with parents or carers are necessary to determine whether the services they need can only be provided by the NHS or whether other

alternatives would be more appropriate and cost effective. Similarly, where such people are ordinarily cared for by their families, there may be a need for some short term respite care arrangements to be provided by the NHS.

DHA and FHSAs contracts for service provision should include a requirement on providers to inform general practitioners and other members of the primary health care team what services are available in their locality.

Transitional responsibility for people in mental handicap hospitals

In addition to seeking to meet the NHS's continuing responsibility for providing health services to people with learning disabilities, purchasers will need to take account of the needs of the residents of the remaining specialist mental handicap hospitals. There are currently some 21,000 people in such hospitals - over two thirds have been there for at least five years. It is likely that many would now be assessed as inappropriately placed in what is, in effect, long term social care in an NHS residential setting, though some will also have chronic health needs in addition to their learning disabilities.

Steady progress is being made with the relocation of residents into community settings. Health authorities should continue to work with matching social services departments in planning the transfer of residents, and resources to support them, to the community by a mutually agreed date, with a view to closing the old mental handicap hospitals as quickly as practicable. The pace of transfer will depend on local circumstances and resources.

In the meantime, district health authorities have a continuing responsibility for the residents of mental handicap hospitals. While the hospitals remain a satisfactory level of care must be maintained. Indeed health authorities should aim to ensure that quality of care in these hospitals improves at least in line with improvements in quality of care generally and that residents have access to general medical services or their equivalent.

NHS Responsibilities to local authorities

Local authorities will look to health authorities to secure through their contracts the services of professional staff, including psychiatrists, mental handicap nurses, psychologists and therapists, to help assess the needs of individuals with learning disabilities and to provide health services for them. Health services professional staff will also need to be made available to provide training, advice and support to local authority staff.

Health authorities will also need to contribute to the preparation of Community Care Plans and consider with local authorities how resources can jointly best be used to provide care. FHSAs will also need to ensure that the views of all GPs and other members of the primary health care team are properly reflected in these considerations. Additionally GP fundholders will need to be aware of the overall approach to and of the principles underlying Community Care Plans in order that they can take these into account when contracting for health care.

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Full use should be made of the arrangements for joint finance, dowry payments and the powers available under Section 28A of the NHS Act 1977. Separate guidance on this will be issued shortly.

This circular should be read in conjunction with the enclosed Local Authority Circular LAC(92)15. "Social Care for Adults with Learning Disabilities (Mental Handicap)" and its annex "Developing Day Services for People with Learning Disabilities (Mental Handicap)", which reinforce general advice to local authorities on developing community care and give specific guidance on the planning of services for this client group.

Further information on the extension of the GP fundholding scheme to include, among other things, mental health services for people with learning disabilities can be found in EL(92)48 and subsequent NHSME guidance.

The following are only a few examples of problems that can arise which may either prevent people with learning disabilities from getting the health care they need, or make their experience of receiving health care much less satisfactory than that of a person without learning disabilities:

- a general practitioner has difficulty examining a person with learning disabilities who refuses to co-operate;
- a hospital doctor is faced in his or her out-patient clinic with a person with severe learning disabilities who has no speech;
- after an appendectomy, the nurses on a general surgical ward have to provide post operative care for a person with learning disabilities who does not seem to understand their requests, or conform to ordinary ward requirements.

With forethought difficulties such as these can be overcome:

- a domiciliary visit or an early or late appointment might make the general practitioner consultation easier by reducing the stress caused by unfamiliar people and surroundings;
- a person with knowledge and experience of people with learning disabilities could be available to facilitate the out-patient consultation, rather as an interpreter is necessary in cases of consultations between patients and doctors with no common language;
- either the staff of the general surgical ward could be augmented with advice from or the temporary help of experienced mental handicap nurses, or early discharge could be arranged, ensuring that proper community nursing is provided.

None of these, or many similar examples that could be given, raises complex issues, but some prior consideration is needed if people with learning disabilities are to be enabled to use the ordinary range of health services and be satisfactorily treated while doing so.

**LOCAL AUTHORITY CIRCULAR****To: The Chief Executive**

Non Metropolitan County Councils)
Metropolitan District Councils)
London Borough Councils)
Common Council of the City of London
Council of the Isles of Scilly

England**The Director of Social Services****October 1992****SOCIAL CARE FOR ADULTS WITH
LEARNING DISABILITIES (MENTAL HANDICAP)****SUMMARY**

This circular gives specific guidance to local authorities on planning services for adults with learning disabilities (mental handicap). It complements and reinforces the general guidance on developing community care set out in "Community Care - the Next Decade and Beyond". Guidance on services for children with learning disabilities is contained in "Children with Disabilities: volume 6 of the Children Act series of guidance and regulations". Guidance on the role of the NHS in providing services for this client group is contained in HSG(92)42.

ACTION

Local authorities should take account of the guidance in this circular when preparing their community care plans and purchasing specifications, and when designing and developing care management and quality assurance arrangements for adults with learning disabilities.

CONTEXT

1. Over the years since the 1971 White Paper "Better Services for the Mentally Handicapped", considerable experience has been developed in providing new forms of home care, day services and accommodation in the community including residential services for people with learning disabilities. There has also been increasing experience of managing the transition from one form of service to another (especially resettling people from long-term hospital care to locally based, smaller scale forms of care). This experience has confirmed that, with appropriate support and opportunities, people with learning disabilities are capable of considerable personal development and of making a positive contribution to society. Few, if any, need to live in hospitals.

2. Over the last twenty years, local authority social services departments have increasingly been seen as the main statutory agency for planning and arranging services, not only for people with mild or moderate learning disabilities but also for those with severe or profound learning disabilities, including some with multiple disabilities or behaviour disturbance. The Government believes this trend is right, and as the changes resulting from the National Health Services and Community Care Act come into force, local authorities will have a clear statutory responsibility for:
 - * assessing and within available resources, making arrangements for meeting the social needs of people with learning disabilities within a mixed economy of care.
 - * bringing apparent housing and health care needs to the attention of the appropriate authorities when consulting with them about the local community care plans.
3. Carers and user groups and providers in the independent sector should be consulted. There is also a clear need to plan services in close collaboration with local education authorities, the Further Education Funding Council, the Employment Service, Training and Enterprise Councils, leisure/recreation departments and general community services.
4. Service planning should be responsive to the findings of assessments and other aspects of care management which should inform future decisions about services including new forms of provision.

POPULATION TO BE SERVED

5. There is no precise information available nationally about the number of people with learning disabilities, or the degree of those disabilities. Evidence from a number of epidemiological studies suggests there are probably between 120,000 and 160,000 adults in England with severe and profound learning disabilities most of whom require considerable help in order to live, initially in their family homes and later in appropriate residential accommodation. This number may be growing, as advances in health care mean people with particular forms of disability have a greater life expectancy. This will result in an increasing number of people with learning disabilities outliving their parents and needing residential care, and a higher proportion of people with more profound or multiple handicaps and consequently higher levels of dependency. Also people with learning disabilities may manifest at an earlier age the health problems associated with old age. Local authorities will need to establish for their community care plans local figures which will take into account local social, economic or other factors, and will enable closer planning between the relevant authorities.
6. In addition there are probably about 30,000 children under 16 with severe or profound learning disabilities whose needs and wishes, and those of their parents need to be determined and taken into account as they approach the transition to adulthood. Finally, there are many thousands of people with a mild or moderate degree of learning disability, whose varying needs for support must also be considered. In particular, they are more likely than the general population to require additional emotional, mental health and social support, and to require increased assistance if they become parents themselves.
7. Of the approximately 120,000 - 160,000 adults in England with severe or profound learning disabilities, the Department estimates that around a fifth live in hospital and NHS community units, just over a quarter live in residential accommodation provided by local authority social services departments or the voluntary or private sectors, and at least half live with their parents or other carers, some in receipt of existing services.

SERVICE PRINCIPLES

8. Authorities should be guided by the general approach to community care set out in the White Paper "Caring for People" (Cm 849), the subsequent policy guidance "Community Care in the Next Decade and Beyond", and "Care Management and Assessment" and by the guidance more specific to the needs of people with learning disabilities set out in this circular.

Services should be planned on an individual basis

9. In the past people with learning disabilities have often not been treated as individuals with very personal needs and preferences, but rather have been offered pre-determined sets of services (and denied others) on the basis of stereotypical notions of what people with learning disabilities need. The individuality of people with learning disabilities should be recognised and the aim in future should be to arrange services on an increasingly individual basis, taking account of age, needs, degree of disability, the personal preferences of the individual and his or her parents or carers, culture, race and gender. Where necessary people should be helped to express their views and preferences either through the development of self-advocacy skills or through an independent advocate. Sometimes people with learning disabilities or their carers will be dissatisfied with the services provided or offered. Where the service is provided by the local authority the complaint should be dealt with under the complaints procedures described in chapter 6 of "Community Care - the Next Decade and Beyond". It will be important to consider what support a complainant with learning disabilities may need in pursuing their complaint about local authority services. Similarly local authorities will wish to consider how they can, where necessary, support individuals and their carers in expressing their anxieties and complaints about services provided by other agencies.

The contribution of parents and carers and resolving conflicts

10. Parents and carers should be fully involved in decisions about the services to be arranged for the individual disabled person as they are usually best placed to know his/her needs and preferences. Sometimes there will be differences of view between people with learning disabilities and their parents/carers over which services are most appropriate. Conciliation and counselling should be offered in such situations, but in general the views of the person with learning disabilities should be respected. There may also be differences of view between parents and professional staff. Every effort should be made to resolve these. Where this cannot be done it is open to the parent to invoke the complaints procedure and seek a formal review.

Continuity of service provision

11. Many people with severe or profound learning disabilities will need support throughout their lives, though the nature of that support needs regular appraisal so that changing circumstances and needs can be identified and responded to. Parents and carers are often understandably anxious about the continuity of service provision, particularly continuity of caring and service provision as they become aged and infirm, and after their own deaths. Although attitudes are changing some parents and carers are concerned about the closure of the traditional mental handicap hospitals precisely because such hospitals seem to offer more assurance about continuity of caring and support than community based services. Whilst examples of progress in developing community care will help to alleviate these anxieties authorities should recognise these entirely legitimate concerns and aim to give assurance that the essential needs of disabled people, including access to specialist health care, will be met on a life-long basis.

PLANNING TO MEET SOCIAL CARE NEEDS

12. The purchasing, provision and commissioning of social care should be seen as an active and responsive process that builds where possible on the expressed wishes and preferences of individuals, recognising their strengths and aiming to meet their needs. Skills in those care management issues specific to people with learning disabilities will need to be developed. Social care refers essentially to the person-to-person support that may be needed in any or all of the following:

- * arranging accommodation that ensures privacy, personal space and an appropriate level of personal security thus helping to make it into a home;
- * providing personal support for daily living in relation to basic activities of life such as eating, dressing and washing;
- * assisting the development of friendships and social relationships;
- * teaching and supporting socially competent behaviour;
- * creating opportunities for the development of personal and social skills and enhancing and maintaining competencies.
- * enabling the use of everyday education, leisure and other facilities in the community;
- * helping develop occupational skills, finding employment and helping to support the individual in work;
- * facilitating access to health care and other statutory services and entitlements;
- * supporting the individual in identifying and expressing his/her own views and choices;
- * counselling to enable the individual with learning disability or his family/carers to make best use of available services;
- * providing social work help and support to enable individuals and families to deal with emotional and practical stresses;
- * arranging appropriate services for the increasing number of older people with learning disabilities including those with additional psychiatric problems.

13. To meet this diverse range of needs, local authorities will need to adopt a co-ordinated approach, involving all relevant departments, agencies, providers and professional inputs (including those of NHS staff who will continue to provide their essential skills), to plan and arrange a wide range of services, where appropriate by contracting them from the voluntary and private sectors. Services should be developed in accordance with the principles referred to in paragraphs 8-11. The following paragraphs and the annex offer specific guidance on planning and assessing home care, day and residential services.

HOME CARE AND SUPPORT SERVICES

14. Home care and support services have five main elements:

- (i) providing reliable help with direct, physical and personal care, and day to day living activities;
- (ii) teaching skills in their own or family homes to increase the independence of people with learning disabilities. It will also be necessary to extend this teaching into people's places of work, learning or daily occupation, on public transport and in various community settings;
- (iii) offering 'sitting services' on a routine basis, in and out of office hours and at times of stress and pressing need;
- (iv) providing information about services and benefits available to people with learning disabilities and their families or carers.
- (v) providing specialist assessment and advice to carers in conjunction with the health provider unit, in order to help carers cope with behaviour disturbance, mental health problems and profound multiple disabilities.

DAY SERVICES

15. Day services are seen both by people with learning disabilities, and their families and carers, as providing vital opportunities for personal development. The provision of suitable day activities is an essential component in social care as outlined in paragraph 12.
16. Traditionally local authorities have sought to create day opportunities largely through the provision of adult training centres. They currently provide about 56,000 day centre places, and for very many people with learning disabilities, these represent a major element of service provision. Inevitably therefore, such centres have come to be viewed as having a key role.
17. In 1989, the Social Services Inspectorate published the report of the first national inspection of local authority day services under the title "Individuals, Programmes and Plans"¹. That report, with the idea it suggested for the future development of services, was generally well received, and forms the basis for the following guidance.
18. Local authorities should plan to shift away from services based on attendance at the traditional adult training centre, towards an approach to day services based on individual assessment and programmes, in which skill learning and vocational preparation are prominent. The aim should be to move towards a personally planned programme of day activities - social, educational, vocational and leisure - which make use of ordinary community facilities wherever practicable.
19. There should be a smooth transition between education and social services and social service departments should identify the need for future services before individuals leave school. It is of particular importance that day opportunities should enable the gains of people's school years to continue to be maintained to enable them to achieve even greater independence. They should be planned to build on the programmes that have been provided by local education authorities with input from health authorities during the school years, to try to meet the expectations of individuals and their families.

20. In some areas, local authorities are moving towards a "resource centre" approach, in which the centre serves as the base for the planning of individual programmes and the provision of some services. People with learning disabilities are also supported in using the education, training and employment opportunities in the locality available to the community as a whole. Under "Help for People with Disabilities" proposals from TECs were invited to develop models of inter agency co-operation including health, social services, voluntary bodies, employers, careers/employment service and training providers.
21. As part of the development of new forms of service, local authorities should give particular priority to provision for people with learning disabilities and special needs including behaviour disturbance. In planning and commissioning these services authorities will wish to take account of the report of the Mansell Group "Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs" which is to be published shortly.
22. In planning day services, social services departments will need to work closely a) with the education service, particularly in relation to making provision for those leaving full time education as required by the provisions of the Disabled Persons (Services, Consultation and Representation) Act 1986, (as amended by the Further and Higher Education Act 1992) and the Education Act 1981, b) with health authorities and health provider units, and c) with those concerned to provide employment opportunities.
23. Recent national and international experience has demonstrated that given the necessary training and support many, including people previously not thought capable of employment are able to work. Authorities should seek to encourage the development of and make full use of the wide variety of potential training and employment opportunities for people with learning disabilities including sheltered workshops and factories, the sheltered placement scheme, supported employment, employment preparation schemes and open employment in a variety of jobs and industries. Consultation with the employment service which offers a range of specialist assessment, rehabilitation and other employment help is advisable.
24. Annexed to this circular is more detailed guidance on the development of day services, which focuses upon the main issues discussed in the 1989 SSI report. Authorities should use this guidance to develop new forms of day services, so that over time existing services are developed and brought into line with the pattern of services recommended.

ACCOMMODATION AND RESIDENTIAL CARE

25. Most adults with severe or profound learning disabilities are likely to need to live other than in their family homes at some point. In considering residential needs local authorities will need regularly to assess and review each individual and the capacity and willingness of his or her family and carers to continue to support the individual and, insofar as resources allow, plan a package of services aimed to ensure that he or she receives any supporting services needed in the setting which offers most scope for individual development and well-being.
26. The need is to continue to move towards arrangements in which people with learning disabilities are treated as individuals, in circumstances where they are supported by people respectful of them as individual human beings and able, in a continuing and stable relationship, to understand their needs and respond sensitively and flexibly. This means, in particular, reappraising the form of housing and support preferred by individuals at different stages in their lives. The ability to arrange an appropriate, individually-based service depends largely, though not exclusively, on the number, type, attitude and training of the staff providing support. This may prove very difficult to achieve in settings accommodating large numbers, as large institutions can have their own, negative effects which are independent of the initial disabilities of those being cared for.

27. Authorities will need to consider what resources are available for developing services, and how these are best used to continue to make progress towards a service based around individuals. In the Government's view there is a wide range of acceptable living arrangements, including sharing with non-disabled people, ordinary housing, hostels, homes and residential communities. All need to be outward looking, closely associated with the general community, and limited in size so that problems of institutionalisation on a large scale are avoided. The key issue to be faced locally in planning commissioning and purchasing services is what range of housing and support services can provide greatest scope in moving towards an increasingly individually-based service able to meet the needs of people as outlined in paragraph 12, while being realistic in terms of resources.

Short-term care

28. When considering the extent and nature of long-term housing arrangements to be provided, authorities should also consider the need for short-term care accommodation. The Department estimates that more than half of all adults with severe or profound learning disabilities live with their parents or other informal carers. One of the services that is important to people with learning disabilities and upon which many parents and carers rely is short-term care, to provide a break from caring when family circumstances require it. Short-term care can also assist in helping a person with learning disabilities make the transition from life with his or her family to living more independently. Finally, short-term care can offer extra opportunities and experience for people with learning disabilities living in various kinds of long-term residential accommodation.
29. Authorities should look imaginatively at developing forms of short-term care sensitive to the needs both of people with learning disabilities and their carers. In particular the development of short-term care through planned short-term placements with "link" families, has often proved both practicable and valued, and should be considered. Another important option is providing short-term care in the person's own home, by arranging to substitute for parents or carers, for a few hours or for a longer period.

RESOURCES

30. Services for people with learning disabilities provided or arranged by local authority social services departments have increased substantially. Nationally, since 1979 identifiable expenditure on such services has increased every year in real terms, and the Government expects that this will continue. The pace at which services can develop in particular localities is, however, a matter for local determination in the light of assessment of need, available resources and competing pressures on services.
31. In preparing their Community Care Plans local authorities will need to consider with health authorities how resources can jointly be best used to provide care. Full use should be made of the arrangements for joint finance and dowry payments. It may also involve health authorities supporting personal social services and housing expenditure out of their main allocation using the other powers available under Section 28 A of the NHS Act 1977. Guidance on joint finance and other payment arrangements between district health authorities and local authorities under Section 28A of the NHS Act 1977 will be issued shortly.
32. While setting out the direction for future service developments, the preparation of community care plans and target setting, this circular places no specific new requirements on local authorities.

ENQUIRIES

Enquiries about this circular and its enclosure should be made to:

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THE DEVELOPMENT OF DAY SERVICES
FOR
PEOPLE WITH LEARNING DISABILITIES

Introduction

1. This document sets out the direction in which the Government believes local authorities should aim to develop day services for people with learning disabilities (mental handicap), and gives guidance on some of the issues which will need consideration. It supersedes all previous guidance on day services.

The individual programme approach to day services

2. It is widely recognised that day services play an essential role in the range of services needed by people with learning disabilities. Historically, most local authority provision has been made through adult training centres. As resources allow, the Government looks to local authorities to develop existing provision, following the principles set out in the general guidance on community care and those set out in paragraph 8 - 11 of LAC(92)15. This means that, increasingly, day services should:

- flow from an assessment of the needs of each person with learning disabilities;

- take the form of a programme of activities specifically geared to meet an individual's needs;
- involve regular review and amendment of the programme in the light of experience and changing needs over time.

Assessment

3. The bed rock of services should be a skilled assessment, and regular re-assessment, of the individual person with learning disabilities, to cover strengths and needs; abilities and potential; physical, sensory and health considerations; particular needs due to race and gender, and the wishes of the individual and his/her family or carer. This will not involve simply administering tests or schedules, but careful observation, discussion and sharing perceptions between staff of all disciplines, family and the individual. Such assessments must of course be recorded so that the information is available both for use in devising a programme and for later cross reference. As a part of the assessment process clear goals should be established and, where necessary, priorities set.

Programmes

4. The programme produced for any individual should consist of a set of activities providing experiences and/or training opportunities which link coherently

to support and reinforce the goals identified in the assessment. Activities may be provided within the adult training centre but increasingly, centres may make use of either general or specially designed activities arranged elsewhere.

Reviews

5. Regular review is important in any needs-led provision. It is only by reviewing an individual's progress, and judging the effectiveness of the programme in meeting his or her changing needs, that responsible decisions can be taken about the adequacy of current activities. It is important that reviews are carried out regularly and fully recorded. They should involve the user, his/her family and other relevant staff and agencies. This process enables monitoring not only of the progress of the individual but of particular elements of service delivery in terms of both effectiveness and continued value for the individual and the service as a whole.

ISSUES FOR CONSIDERATION

6. The report of the national inspection of day services by the Social Services Inspectorate, published as "Individuals, Programmes and Plans" identified certain issues which service purchasers and providers will wish to take account of in developing the service.

Policy and Planning

7. Day services need to be considered as an element in individual programmes for people with learning disabilities. They should be planned as an integral part of the overall set of social care services on the basis of an adequate information base about the number of such people and their needs. In developing such a base social services departments should liaise with the education services and district health authorities and consider the needs of potential users outside the area e.g. in residential schools. The period of transition between residential or day school and adult services is particularly important.

8. The aim should be to build on the existing pattern of services in the light of this developing picture of the needs of people with learning disabilities in the area. Information on general service requirements obtained from individual reviews should be fed back into the preparation of community care plans.

Form of service

9. Access to and use of ordinary facilities is an essential aspect of living in the community; and in the area of activities broadly described as day services, some use of ordinary facilities is likely to be appropriate. Social services departments will wish to consider various options for the provision and purchase of elements of service. It may, for example, sometimes be appropriate to support a person

with learning disabilities in the use of ordinary services, for example, by arranging for a friend or volunteer to accompany the person when s/he attends an adult education class. Alternatively, it may be sometimes more effective to provide a special service within ordinary facilities, for example, a class for people with learning disabilities within a college of further education, offering special teaching but seeking to afford opportunities to use ordinary college facilities and mix with fellow students. Third, it may sometimes be in the best interests of the service user to receive a service within a day centre for people with learning disabilities. Some people can gain from off the job training to develop the personal and other skills needed whilst others may benefit more from training in the work place. Decisions will rest both on individual need and local circumstances.

Personal and Social Development

10. Like everyone else, people with learning disabilities need a range of social skills to be able to contribute to a life in the community and relate to other people. They will often need appropriate opportunities and teaching to gain these skills, improve their social competence and enhance their ability to communicate and relate to other people. This help can be given both directly and indirectly. Directly, it involves the structured teaching of new skills and appropriate forms of behaviour. Indirectly, it can be acquired as an element within any day activity even when the primary aim of that activity is vocational, recreational or educational.

11. Social education will need to be concerned with social and personal relationships. People with learning disabilities have the same range of emotional, friendship and companionship needs as other people, but may need help and support in making relationships with other people with learning disabilities, and with their non-handicapped peers. 'One to One', funded by this Department, have produced an interesting resource pack to help in establishing schemes to encourage people with learning disabilities to develop their network of friendships.

12. The sexuality of people with learning disabilities is an issue which needs to be openly addressed by users, carers and staff, clear guidelines should be prepared and appropriate education provided. The aim should be to enable people with learning disabilities to understand and come to terms with their sexuality and be helped to express their needs and feelings in ways which are acceptable to themselves as well as society. To enable them to do this will require guidance, education and sensitive support. This knowledge will help in development towards maturity and assist possibly vulnerable individuals to protect themselves against the risk of exploitation and the threat of problems such as sexual abuse, unplanned pregnancy or exposure to Aids.

Leisure, Sport and Recreation

13. Leisure pursuits, either individual or group, will serve many of the same purposes for people with learning disabilities, in terms of personal satisfaction, relaxation and sense of achievement as they do for anyone else. But involvement in sports and leisure activities can meet more specific purposes such as community integration, educational experience and social development and should be considered as part of an individual programme. Recreational activities such as music, art, dance and drama can also be part of a therapeutic programme. Such programmes aim to use the recreational activity to overcome communication difficulties by enabling a person to find expression through an artistic medium. If an activity is intended to serve a distinct therapeutic need rather than simply to provide recreation, it will require input from specialists, e.g. therapists.

14. Staff will need to consider, particularly in relation to more physically demanding sport or recreation, the question of risk. People with learning disabilities should, of course, be allowed to take reasonable risks in their recreational and sporting activities. Some strenuous forms of sporting activity will not, however, be suitable for people who have certain physical disabilities or where specific medical conditions such as epilepsy are present. Staff will need to be aware of any circumstance that prevents people from engaging in these, for example, those with Down's Syndrome who

have Atlanto-Axial Instability. (Advice is available in the Chief Medical Officer's letter of the 28th May 1986, CMO 86/9.) Full discussions should take place with the individual and his carers in the context of the assessment and include appropriate advice from health professionals.

Education

15. People with learning disabilities have, since the transfer of the junior training centres in 1971 benefitted from the resources of the education services. Experience has shown that, given appropriate services and a long term teaching input, many are able to achieve a much higher level of competence in educational work, including numeracy and literacy, than was previously considered possible. It is vital that gains made in the education service are built on at the time of transition to adulthood, which is believed to be a period when further development of these achievements and progress from them are of particular importance. Careful arrangements must be made for transition between education and social services provision when pupils leave school and consideration given to their need for continuing educational input.

16. According to individual need, continuing educational input may be provided in a number of ways; by attendance at a further education college or adult education institute, by secondment into day services of education tutors, or by provision of the necessary educational input by the local authority day services staff. Decisions on the most

appropriate provision will be a matter for joint discussion between service users, social services and education departments.

17. Additionally there is a wide range of further education classes for adults which serve the general public. In many cases, day centre staff have accessed a number of these for service users, often with great success. Careful preparation and support of students with learning disabilities themselves and those teaching staff without prior experience of them are important if such opportunities are to be taken successfully.

18. The increasing use of computers and the subsequent development of skills in Information Technology in both schools and day services has led to significant progress. Day services should continue to build on this.

Involvement in employment

19. The opportunity for involvement in employment can have many benefits for people with learning disabilities. First, participation in a paid job will help them to achieve greater social independence and self-assurance. If they go out to work and pay their own way in the world, they are likely to see themselves as more valued members of the community making a contribution to that community. Involvement in employment can also help with integration into society by enabling wider contact and a new pattern of social skills. Finally, it is important that the country makes best use of the skills and potential

contribution from all its citizens. Whilst gains may be most obvious in the case of full-time paid employment many of them will be obtainable from participation in other employment related activities.

20. It should not be assumed that "self-reliance" in terms of employment is matched by independence in respect of people's living circumstances. Because there are non-vocational areas of people's lives which are essential to employment - getting up on time, being clean, wearing appropriate clothes, handling money to buy lunch, catching a bus etc - few people with learning disabilities who secure and hold a job do so without reliable assistance from others in the non-vocational areas of their lives.

21. Ideas about the possibility of employment for people with learning disabilities in open settings have changed considerably in recent years. There is now widespread acceptance of the fact that many people previously thought incapable of work can do so provided that the necessary training and support is made available particularly in the early stages of employment. There is a growing body of useful experience both within this country and abroad. People with learning disabilities are increasingly working in open employment, in sheltered workshops and in a range of special supported employment schemes. Opportunities now cover many jobs and industries.

22. Providers and purchasers of day services have an important role to play in training people for employment, by equipping them with both general and

social skills. The individual programme plan approach should be used in relation to work activities, which should be clearly related to the assessment of individual needs and potential for further development. In this way someone who might potentially be a candidate for open or sheltered employment could receive training in such areas as interpersonal skills, development of co-ordination, development of appropriate work habits and attitudes, co-operation with fellow workers, response to authority, assumption of responsibility and ability to follow through tasks and adapt to difficult situations, all of which will enable a job, once found, to be satisfactorily maintained.

23. Training and Enterprise Councils are responsible for the delivery of the Government's training programmes. People with disabilities, including those with a learning disability, are eligible for these programmes and indeed have priority access. The training programme will offer appropriate skills and qualifications and can also offer the support and guidance needed by those with learning disabilities. Local authorities are therefore encouraged to liaise with their local Training and Enterprise Council so that people with learning disabilities can benefit from the training and developmental opportunities available.

24. The assistance of specialist employment agencies may also be helpful and there is increasing expertise available. For example, within the Employment Department's Employment Service, locally based Disability Employment Advisers work in Placing

Assessment and Counselling Teams. They can advise about the Employment Department's range of mainstream provision and the special help available for people with disabilities. Additionally, experience has shown that it is possible for firms or co-operatives to be established specifically to provide work opportunities for people with learning disabilities. Staff within resource centres may need to develop or access additional skills and knowledge both in business management and job finding to make best use of opportunities. They will already be aware that in this area, as in others for people with learning disabilities, it will be necessary to provide structured teaching so that people with learning disabilities can learn from their experience of employment. Consideration should be given to the possibility of people with learning disabilities taking advantage of the new pattern of training opportunities under the National Council for Vocational Qualifications.

Special Needs

25. In assessing the requirement for day service facilities, account must be taken of those users who have additional needs. These will include people who have profound learning disabilities or who have other disabilities which may preclude them from benefitting from the normal range of day activities provided for other people within or outside a day centre. The number of such people is increasing, as more people with more profound learning disabilities now survive longer and the reduction in hospital admissions has led to more people being cared for in the community.

26. To meet the requirements of this group of users special needs facilities (units) have been developed, with most places being situated within existing day centres. The special needs unit should not be seen simply as a place where people with profound learning disabilities receive passive care. The unit should be a specialised resource centre, offering intensive treatment and support. It could serve as a base for such users from which they could be exposed to increasingly demanding tasks and experience elsewhere. The time spent in the special needs unit should therefore be varied and rewarding, provide stimulus and challenge, and aim at helping the user to develop his or her maximum potential and independence.

27. An individual assessment of a user's needs, followed by the drawing up of a recorded programme of action, is an essential basis for establishing the pattern of activities in a special care unit. The move towards a new pattern of day services for people with learning disabilities, and the changing role of the ATC, will have obvious implications for those within the special care group. The same principles that apply to day services provision for all other people with learning disabilities should apply equally to those with profound disabilities. These require that a person's needs for day services are assessed on an individual basis and that an individual programme plan is developed, taking account of the person's own preferences in so far as these can be ascertained, and those of carers.

28. It may be that the individual programme plan drawn up for the most profoundly disabled people will call for a number of their activities to be undertaken within the day centre. Decisions on what use profoundly disabled people can make of general community facilities will be a matter for assessment, but their activities, wherever undertaken, will need to facilitate personal development and encourage the teaching of basic self-help and social skills. Activities may include both group activities and intensive teaching on a one-to-one basis, which will require the specialist staff skills which are available within some day centres and colleges. Input from staff external to the unit with particular skills, eg music or drama, will widen the experience available to users.

29. The involvement of profoundly disabled people in community day services raises the question of transport arrangements. Here, as with the arrangements for the user to go to and from the special care unit, the aim should be to keep travelling time to a minimum.

30. There will be a need for the ATC/special care unit staff - as well as other day services staff - to establish contact with a wide variety of other agencies and professionals to ensure that the necessary facilities are available to all people within the special care group. Profoundly disabled people may have extra special needs, and may require additional input either directly or as advice to staff (eg from a community mental handicap nurse or

therapist on feeding techniques). It is important that authorities identify the particular contribution required from the staff of other agencies such as district health authorities and seek to negotiate its provision.

31. Provision also needs to be made for other groups of people with learning disabilities whose needs extend beyond those traditionally catered for by day services. These include users with behaviour disturbance or sensory disabilities, as well as those from minority ethnic groups and the elderly. The Department of Health will shortly be publishing the report of the Mansell Committee "Services for People with Learning Disabilities and Challenging Behaviour Mental Health Needs." This will be of assistance to authorities in planning their service.

Links with Families

32. The most important lifelong stable relationship for many people with learning disabilities is the relationship with their families and it is important that this should be maintained. Perhaps 70% of people using day services live with their families, who quite properly expect to have a significant involvement in the user's daily life and will have a particular wealth of knowledge and information about the user. General policy guidance has stressed the importance of the proper involvement of families when assessing the needs of people for social care, and this applies in relation to day services. In addition, many carers will come to value the day or resource centre as a focal point and as a source of

advice, support and respite. There will be an expectation that such support should be available if required, not only for the present centre users but also those who for a range of reasons, for example open employment, transfer to full-time education are now no longer attending. Wherever practicable, provision to meet these demands should be built into staffing establishment. Consideration should be given in the assessment process to whether the necessary help and support can most appropriately be provided by centre staff or other professionals, for instance from a Community Team, involved with the user and his or her family.

Staff Training

33. The implications of a change in the way in which day services are organised will be considerable for staff working within the existing service. If staff are to perform different functions than hitherto with a fundamental re-orientation in their attitudes towards an individual approach to meeting users' needs, they will require the training necessary to allow them to perform these functions well and to help alleviate their anxieties and uncertainties. There will be a need for staff to extend and develop their existing skills and some may move in the direction of becoming specialists in particular areas. Service managers will need to plan for the availability of appropriate qualifying as well as in-service training. Consideration should also be given to opportunities to gain National Vocational Qualifications.

34. Existing staff should be encouraged to acquire new skills appropriate to a service provided on the basis of individual assessments and individual programme plans supporting individual development. As this approach, together with the distinction of purchaser and provider roles, will involve a radical change for some staff, there will be a need for in-service training and development. This could be arranged, for example, through workshops and by means of continuous in-service training programmes which should be designed to make maximum use of existing staff skills. The aims should be to help staff understand the new approach, the thinking behind it, and how it will affect staff practice. Training should cover a wide variety of subjects, including the role of further education for adults, employment opportunities for people with learning disabilities etc. The changed role of the ATC will have an appreciable effect on the skills that staff require to do their job. The skills needed will be those appropriate to the core functions of the day centre; assessment, co-ordination, planning, special care, etc. As indicated in the SSI Report on Day Services, the following skills are essential to assist staff in carrying out their tasks:

(i) knowledge about people with learning disabilities and how best to teach and help them to develop their own skills;

(ii) how to translate the process of assessment into service for individual clients by developing programmes and activities based on assessed needs;

(iii) developing skills in keeping and using clients' records, and in reviewing individual programmes;

(iv) an understanding of the social needs of people with learning disabilities, respecting and responding to their views and choices, as well as those of their families;

(v) knowledge of the framework of the wider services available for people with learning disabilities;

(vi) working with other agencies and professions with an appreciation of their contribution;

(vii) making the best use of developing community services and new resources.

35. Staff working with people with special needs will continue to require regular in-service training, so that they can both increase their knowledge of their client group and receive up-to-date information about relevant teaching skills and techniques. This should be supplemented by appropriate external training courses, seminars and workshops as necessary.

Risk

36. An element of risk is inherent in a policy of a greater degree of self-determination and wider integration into the community. As people with

learning disabilities benefit from a more stimulating and interesting life experience, they will inevitably be exposed to a greater degree of risk. It is important that such risks are carefully judged, not taken lightly or ignored, and are acceptable in the light of the potential benefits to the individual. It is important to ensure that medical advice is sought on the degree of supervision or safety measures which may be appropriate. The policy of the agency on risk taking should be clearly specified in operational terms and made available to service users, carers, staff and other involved agencies. The general policy will need to be translated into decisions on individual circumstances.

Advocacy

37. The values of choice, self-expression, and achievement of maximum independence have been recognised as of increasing importance for people with learning disabilities. Promoting individual choice is a central message of "Caring for People" for all client groups. The SSI inspection reported that there is already much encouraging practice on developing advocacy skills from which to learn. Underpinning all activities will be a move towards maximum achievable independence. Work on self-advocacy skills will be a central part of this. People should be supported and helped to speak for themselves and make realistic choices. More able users will be able to exercise and express choice on many matters, but for the most disabled choice will only be possible in limited areas. Nevertheless their views and wishes should be sought, regarded as

important, and taken fully into account in the design of the programme. Approaches such as Citizen Advocacy may help in this process.

TIM YEO'S SPEECH

MENCAP CONFERENCE - POSITIVE IMAGES: POSITIVE ACTION

26 October 1992

CONVERTING RIGHTS INTO REALITIES FROM THE PERSPECTIVE
OF HEALTH AND SOCIAL SERVICES

Firstly may I thank you for inviting me to share in your conference today. It is an exciting time for everyone involved in Mencap and I wish you every success in what you are seeking to do.

You have chosen a challenging theme for this conference. "Positive images: positive action". It slips easily off the tongue but how difficult it is to change peoples' attitudes towards people with learning disabilities; to take action which really does result in better opportunities and services for people with learning disabilities and their families. Yet we should not underestimate the considerable progress which has already been made. Many more people are able to take their place in society, it is now much more widely recognised that people with learning disabilities make a positive contribution to the whole community and many more opportunities are available to them. There is however absolutely no room for complacency; a great deal remains to be done and we all have a part to play in ensuring that people with learning disabilities are not discriminated against because of their disability.

RIGHTS

You have asked to speak on converting rights into realities from the perspective of health and social services. This raises the question of "what rights"? Stephen Dorrell, my predecessor summed them up in the policy statement he made at your conference last year and I have no hesitation in endorsing what he said. Let me summarise the values and principles which should underlie the development of services:

"..... people with a learning disability - of whatever degree - are entitled to be treated with the same respect and dignity as everyone else [their] own views and wishes must be taken seriously and respected at all times

"..... [they] should have their health and social care needs assessed on an individual basis, and not be offered predetermined sets of services because of ill-considered or outdated notions of what people with learning disabilities actually need or should be satisfied with

"..... [they] have the same rights in relation to statutory services as anyone else. This includes the right of access to both primary and secondary health care as well as the right to have their needs for social care assessed." It means incidentally that the patients charter applies equally to them as it does to any other patient."

SETTING THE FRAMEWORK FOR ACTION

So how do we convert this into reality. No one person or group will be able to achieve this on their own. It is a shared aim and we must work together to secure it.

The Government has a key role to play. It sets the framework within which local services are developed. Our NHS and Community Care reforms are designed to ensure that the services of the future are consumer orientated, that peoples' needs and wishes are properly taken into account and that people in the more vulnerable groups in our society receive better care.

Earlier this month Virginia Bottomley announced several new measures through which we propose to ensure the effectiveness of these reforms. I would like briefly to outline two which I believe will be of particular interest to everyone here today.

FINANCE

The first concerns finance. We had given a commitment that our community care policy will be fairly resourced and that the sum transferred from DSS will be separately identified. We have now fulfilled that commitment. The total extra community care finance for social services authorities in England next year will be £539 million. This comprises a transfer from social security of £399 million, with an addition of £140 million - over 35 per cent - to cover the cost of the extra services needed.

For the first three years of the new policy there will be a mechanism for helping local authorities to protect the annual increases in the main new elements of community care finance as this money becomes available to them for the first time. Our aim has been to introduce the policy with the minimum interference with local discretion over resources generally. We are therefore arranging that next year there will be a temporary measure of ring fencing through a transitional special community care grant. It will not cover the whole of local authorities' spending on community care or adult personal social services. In fact it will leave the bulk of personal social services spending and community care spending to authorities' discretion. But it will cover the extra community care finance for 1993-94 and the increases in the social security transfer to local government in the following two years.

I know that some of you will be disappointed that we have not decided to ring fence resources for specific client groups and in particular for people with learning disabilities. However we did not feel that this would be consistent with our aim of interfering as little as possible with authorities' discretion.

The grant will enable us to re-enforce key objectives of our policy. We intend to use it to give further impetus to the development of a mixed economy of care by requiring that authorities spend at least three quarters of the grant next year on community care services provided by the independent sector. This includes both the private and voluntary sectors (including housing associations) and it applies to both residential and non-residential services. In the following years the Government is minded to impose similar conditions, though it may be appropriate to vary the percentage to be spent in the independent sector.

DIRECTION ON CHOICE OF RESIDENCE

The second measure which we have taken is concerned with ensuring that individuals have an influence over decisions regarding residential care. You do not need me to tell you how important such decisions can be. The right residential setting can often be the cornerstone of a successful service. People want to be able to choose where they live. Some will want to stay in their own locality whilst others may wish to move to a home close to relatives or friends in another part of the country. Some may want to choose a home run by their church, or religious group or a particular organisation.

Of course it won't always be possible to provide exactly what the client would like but every effort should be made to listen to their views and develop solutions together. At present people can exercise their choice by spending their income support in homes of their preference, provided that costs can be covered. We are determined that this freedom of choice should remain after April 1993. So we have decided to issue a binding direction which will give individuals the power of choice they should have - within obvious and practical limitations. We are currently consulting on a draft direction on which Mencap, amongst others, has been invited to comment.

GUIDANCE ON SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

The measures I have referred to so far have affected all client groups but the Government has also taken a number of positive steps to improve services specifically for people with learning disabilities. Last year Stephen Dorrell restated our policy on services for people with learning disabilities in the context of our NHS and Community Care reforms so that we all could be clear about the type of services to be developed and the values and principles that should underlie them. We have since consulted on draft guidance to health and local authorities on the development of these services. Many took the opportunity to comment including I am pleased to say some people with learning disabilities. Indeed one group sent us video of their discussion of the guidance and how they wanted the services to develop.

The proposed guidance was widely welcomed. We have made some amendments to take account of the comments received but the main thrust of the documents remains unchanged. The guidance is being issued to authorities today. It will provide the framework for the development of services and help health and local authorities to determine how best to make use of the resources available to them.

The comments we received centred mainly around three issues - resources, demography and village communities. I am afraid that I am not able to announce any new finance specifically to develop services for people with learning disabilities - though I dare say this will not be a great surprise to you. I believe that the measures we have taken to finance community care and to ring fence the additional money being provided will benefit all client groups. In using these resources to provide services for people with learning disabilities the statutory authorities will continue to be able to make full use of the arrangements for joint finance and dowry payments.

Health authorities may also support personal social services and housing expenditure out of their main allocation using the other powers available under Section 28A of the NHS Act 1977. Guidance on joint finance and other payment arrangements between district health authorities and local authorities under the 1977 Act is to be issued shortly.

The second issue which featured in the comments we received was that of demography. Those consulted felt that insufficient recognition had been given to the demographic factors affecting the demand for services for this client group. Clearly this is something which needs to be considered by the authorities planning the development of services. We have therefore added a section on demography to the NHS guidance and the section in the local authority circular has been strengthened.

We also received a large number of comments questioning the inclusion of communities in the range of residential options. The overwhelming majority of respondents felt that experience had shown that it was not possible in the larger setting of village communities to meet individual need or to integrate people with learning disabilities into the wider community. We have therefore decided to omit any specific reference to village communities in the guidance.

We are aware that there are those who feel that village communities provide a safe and cost effective environment for vulnerable people. The guidance does not prevent purchasers providing places in village communities when individuals and their families wish it. However purchasers would need to be satisfied that the village community met the criteria set out in the guidance - namely that it was outward looking, closely associated with the general community, limited in size so that the problems of institutionalisation were avoided, and that it regarded its residents as individuals, supporting them with staff who respected them as individuals and were able in a continuing relationship to understand their needs and respond flexibly and sensibly.

Perhaps whilst on the subject of residential services I might also mention that we will also be issuing shortly as part of the series "Caring for Quality" a document called "Guidance on Standards for the Residential Care Need of People with Learning Disabilities" which is based on work done by the Social Services Inspectorate. Progress and thinking about the provision of accommodation and residential care is rapid and I believe that the document can be, as the Chief Inspector says in his preface, a basis for flexible and creative use in setting standards and in developing agencies' own criteria for judging the quality of accommodation, purchased or provided for people with learning disabilities.

As I have said the main thrust of the guidance on the development of services for people with learning disabilities which is being issued today remains unchanged from the draft circulated for consultation. We want health and local authorities to develop a range of services to meet the individual health and social care needs of people with learning disabilities. This will involve listening carefully to what clients and their families and carers have to say using advocates where necessary and translating their needs and wishes into services tailored to them as individuals.

Inevitably there will be resource constraints but by developing solutions together services are more likely to meet the clients real needs and make the best use of the opportunities and resources that are available.

STAFF - AN ESSENTIAL RESOURCE

Staff are one of the key elements in a successful service. Their skills and experience are a precious resource which needs to be used to best advantage. Manpower planning and training are issues which health and local authorities need to consider in developing their community care plans. There are some complex issues about the ways in which the skills of mental handicap nurses should be made available to local authorities in connection with the development of the new pattern of services and the Department has been addressing these. Our aim is to ensure that there are no bureaucratic impediments to prevent local authorities benefitting from nurses' skills.

SHARED TRAINING GRANT PROGRAMME

Staff working in agencies that provide services for people with learning disabilities need to know about wider developments that affect their clients. Training is very important in this context, particularly training which allows staff from different agencies to share their experiences. The Department has over a number of years contributed to this process by providing money for innovative training projects on issues which affect people with learning disabilities through our scheme of Learning Disability Shared Training Grants. This scheme promotes shared training of staff across agencies involved with the client group, with the aim of increasing the effectiveness of services delivery.

These Shared Training Grants have tended to receive a little attention. I think this is a pity. Some exciting work has been undertaken, work which has stimulated further developments in the field. A range of training opportunities has been funded from this modest but important budget including courses, conferences, videos, training packs, and evaluations. Projects have included many themes, including advocacy, behaviour disturbance, the needs of profoundly handicapped people, and employment for people with learning disabilities; and they have encouraged inter-agency and inter-professional collaboration.

As a first step to disseminating the work more widely in the Summer the Department held a workshop for agencies that have received funding in recent years. A report of the work shop, which highlights what has been achieved to date is now available.

This brings me to another initiative which the Department has taken to help disseminate good practice. Both health and local authorities have experienced difficulty in meeting the needs of people with learning disabilities and behaviour disturbance or mental illness. Responding to the demands of this small but significant client group is crucial to the success of our community care policy for people with learning disabilities.

Unless services respond well to their needs they can occupy disproportionate amounts of time and money, as well as causing heartache for themselves and their relatives and carers. Insensitive placing of people with severe behaviour disturbance in the community without adequate support can lead to prejudice against people with learning disabilities in general.

To help authorities develop services for this particular client group the Department last year set up a small working group including people who had achieved some success in this very specialised field. The group's task was to analyse how the successful services had approached their task, and synthesise the findings into practical guidance from which further local provision might grow. The group was chaired initially until his tragic death by Peter Searle, then Director of the Mental Health Foundation and I would like to take this opportunity to express my appreciation of his contribution to its work. I would also like to thank Professor Jim Mansell of the University of Kent who very kindly took over the Chairmanship at short notice and enabled the group to complete its work.

The Report has now been submitted to the Department. There is already a lot of information available about service models for people with learning disabilities and behaviour disturbance. This report however focusses on the task facing commissioners of services - particularly appropriate as the purchaser/provider split extends from the health field to social services and identifies a number of factors relevant to success. It will be a useful document for all concerned with the needs of this client group. I am discussing arrangements for publishing disseminating and for following it up.

ROLE OF VOLUNTARY SECTOR

So far I have spoken primarily about action by the Government and the statutory authorities in developing better services for people with learning disabilities. In closing I would like to refer to the role of the voluntary sector. It has two crucial functions neither of which could be replaced by state institutions. I make no apology for mentioning first and foremost the campaigning role. Voluntary organisations have a distinguished tradition of securing important changes in both public attitudes and government policy on behalf of their client groups. Long may this continue. But of equal importance now is the opportunity created by the purchaser/provider split. It is the purchaser - either the health authority or the local authority - which performs the vital strategic function.

So local voluntary organisations should be addressing themselves urgently to these authorities with that aim of ensuring that local purchasing (including joint commissioning) policies reflects local needs.

The second function is to take part in the process of delivering high quality community care by contracting with local authorities as providers of services. The opportunity for this has been enormously expanded by the fact that 34 per cent of the ring fenced money available to LAs must be spent in the independent sector. In addition the Government has made clear its wish to see more independent sector participation in non-residential services - both day care and domiciliary.

Over the years Mencap have been at the forefront of new service development. This experience, and their close relationships with parents and carers has made them effective campaigners. Furthermore, Mencap have shown in the positive action which they have taken re-examine their purpose and image and in the publication of their new manifesto that they take their task seriously. I wish them every success.